Wellmark BlueCross BlueShield of Iowa

An Independent Licensee of the Blue Cross and Blue Shield Association

B E N E F I T B O O K L E T

State of Iowa
PROGRAM 3 PLUS

Classic Blue / Blue Rx Preferred Prescription Drug

If you have questions about your coverage or about a specific claim, call the Wellmark Blue Cross and Blue Shield of Iowa customer service unit for State employees.

Des Moines Area: **515-245-5185** ● Toll Free: **800-622-0043**

For Precertification: **800-558-4409**

Form Number: Wellmark IA Grp (SOI Program 3 Plus)

Group Effective Date: 10/1/2007
Print Date: 5/20/2008
Coverage Code: M4E M4F X6G
Version: 1/07 (as amended on 1/1/2008 and 7/1/2008)

Notice

The official Plan Document that describes the benefits for which you are eligible under your group health plan is available, in print, in the department of your employer or group sponsor responsible for the administration of your health plan. A printed copy of the Benefit Booklet further describing benefits for which you are eligible under your group health plan is also available, upon your request, by calling the Customer Service number on your ID card.

This notice is attached to an electronic copy of the Benefit Booklet for your group health plan. Wellmark Blue Cross and Blue Shield of Iowa is not responsible for any alterations or modifications that may be made to an electronic copy or other differences that may exist between the attached electronic copy of the Benefit Booklet and the printed Benefit Booklet. Any alterations, modifications, or differences contained in the electronic copy to which this Notice is attached that are not consistent with, or that conflict with, the printed Benefit Booklet issued to your employer or group sponsor are not binding on Wellmark Blue Cross and Blue Shield of Iowa. In the event of any inconsistency or conflict between the printed Benefit Booklet and an electronic copy, the terms of the printed Benefit Booklet shall govern.

Wellmark BlueCross BlueShield of Iowa

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Amendment to Your Benefit Booklet

This amendment applies to your benefit booklet, effective January 1, 2008, except as noted otherwise. The headings refer to benefit booklet sections. Please review the amendment and keep it with your benefit booklet.

Details - Covered and Not Covered

Morbid Obesity Treatment

This coverage description is revised as follows.

You are covered for weight reduction surgery provided you meet eligibility criteria for age and medical condition and history. Not all procedures classified as weight reduction surgery are covered. Prior approval for weight reduction surgery is strongly recommended. For information on how to submit a prior approval request, refer to *Prior Approval* in the *Notification Requirements and Care Coordination* section of your benefit booklet, or call the Customer Service number on your ID card. For the criteria we use to determine prior approval, you may call the Customer Service number on your ID card or visit our Web site, *www.wellmark.com*.

Speech Therapy

This coverage description is revised as follows.

You are covered for speech therapy services provided outside a facility. You are not covered for speech therapy services not coordinated through home health services when the services are received through a home health agency.

Physicians and Practitioners

The following is added to the list of covered practitioners.

Speech Pathologists.

Audiologists *(effective July 1, 2008)*—but only for services that are otherwise covered. Any exclusion of routine hearing exams or hearing aids in your benefit booklet remains in effect.

General Conditions of Coverage, Exclusions, and Limitations

Medically Necessary

Under Conditions of Coverage*, the definition of* Medically Necessary *is deleted and replaced with the following*.

A key general condition in order for you to receive benefits is that the service, supply, device, or drug must be medically necessary. Even a service, supply, device, or drug listed as otherwise covered in *Details – Covered and Not Covered* may be excluded if it is not medically necessary in the circumstances. Unless otherwise required by law, Wellmark determines whether a service, supply, device, or drug is medically necessary, and that decision is final and conclusive. Even though a provider may recommend a service or supply, it may not be medically necessary.

A medically necessary health care service is one that a provider, exercising prudent clinical judgment, provides to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and is:

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
  - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community;
  - Physician Specialty Society recommendations and the views of physicians practicing in the relevant clinical area; and
  - Any other relevant factors.
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease.
- Not provided primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the illness, injury or disease.

An alternative service, supply, device, or drug may meet the criteria of medical necessity for a specific condition. If alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, we reserve the right to approve the least costly alternative.

If you receive services that are not medically necessary, you are responsible for the cost if:

- You receive the services from a nonparticipating provider; or
- You receive the services from a participating provider in the Wellmark service area and:
  - The provider informs you in writing before rendering the services that Wellmark determined the services to be not medically necessary; and
  - The provider gives you a written estimate of the cost for such services and you agree in writing, before receiving the services, to assume the payment responsibility.

  If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined are not medically necessary, the participating provider is responsible for these amounts.
- You are also responsible for the cost if you receive services from a provider outside of the Wellmark service area that Wellmark determines to be not medically necessary. This is true even if the provider does not give you any written notice before the services are rendered.

Investigational or Experimental

Under General Exclusions*, the definition of* Investigational or Experimental *is deleted and replaced with the following*.

You are not covered for a service, supply, device, or drug that is investigational or experimental. A treatment is considered investigational or experimental when it has progressed to limited human application but has not achieved recognition as being proven effective in clinical medicine.

To determine investigational or experimental status, we may refer to the technical criteria established by the Blue Cross and Blue Shield Association, including whether a service, supply, device, or drug meets these criteria:

- It has final approval from the appropriate governmental regulatory bodies.

- The scientific evidence must permit conclusions concerning its effect on health outcomes.
- It improves the net health outcome.
- It is as beneficial as any established alternatives.
- The health improvement is attainable outside the investigational settings.

These criteria are considered by the Blue Cross and Blue Shield Association's Medical Advisory Panel in publishing a Reference Manual for consideration by all Blue Cross and Blue Shield member organizations. While we may rely on these criteria, the final decision remains at the discretion of our Medical Director, whose decision may include reference to, but is not controlled by, policies or decisions of other Blue Cross and Blue Shield member organizations. Copies of the evaluation criteria and the reference manual information for a specific service, supply, device, or drug are available upon request.

If you receive services that are investigational or experimental, you are responsible for the cost if:

- You receive the services from a nonparticipating provider; or
- You receive the services from a participating provider and:
  - The provider informs you in writing before rendering the services that Wellmark determined the services to be investigational or experimental; and
  - The provider gives you a written estimate of the cost for such services and you agree in writing, before receiving the services, to assume the payment responsibility.

  If you do not receive such a written notice, and do not agree in writing to assume the payment responsibility for services that Wellmark determined to be investigational or experimental, the participating provider is responsible for these amounts.

Personal Convenience Items

Under General Exclusions*, this provision is deleted and replaced with the following*.

You are not covered for items used for your personal convenience, such as:

- Items not primarily and customarily manufactured to serve a medical purpose or which can be used in the absence of illness or injury (including, but not limited to, air conditioners, dehumidifiers, ramps, home remodeling, hot tubs, swimming pools); or
- Items that do not serve a medical purpose or are not needed to serve a medical purpose.

Factors Affecting What You Pay

Payment Arrangements

Under Payment Arrangements*, the designations and descriptions of amounts shown on the* Explanation of Benefits *statement, which you receive when a claim is processed, are revised.*

The savings from payment arrangements and other important amounts will appear on your Explanation of Benefits statement as follows:

- *Network Savings,* which reflects the amount you save on a claim by receiving services from a participating provider. For the majority of services, the savings reflects the actual amount saved on a claim. However, depending on many factors, the amount we pay a facility could be different from the covered charge. Regardless of the amount we pay a facility, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.

- *Amount Not Covered,* which reflects the portion of provider charges not covered under your health plan and for which you are responsible. This amount may include services or supplies not covered; amounts in excess of a service maximum, benefit year maximum, or lifetime benefits maximum; reductions for failure to follow a required precertification; and the difference between the amount charged and the maximum allowable fee for services from a nonparticipating provider.
- *Amount Paid by Health Plan,* which reflects our payment responsibility to a provider or to you. We determine this amount by subtracting from the amount charged amounts such as deductible, coinsurance, copayments, amounts representing any general exclusions and conditions, and network savings, as applicable to your claim.

Please note: We have redesigned the *Explanation of Benefits* statement (EOB) to make it easier to understand. One change is the use of member friendly terminology and definitions. In accordance with the changes to the EOB, the current benefit booklet terms of *provider savings, benefit limitations, settlement amount,* and *billed charge* should be understood as *network savings, amount not covered, amount paid by health plan,* and *amount charged,* respectively. (Also see the *Glossary* definition of *amount charged* later in this amendment.)

Special Programs

The following provision is added.

We evaluate and monitor changes in the pharmaceutical industry in order to determine clinically effective and cost effective coverage options. These evaluations may prompt us to offer programs that encourage the use of reasonable alternatives. For example, we may, at our discretion, temporarily waive your payment obligation on a qualifying generic prescription drug purchase.

Visit our Web site at *www.wellmark.com* or call us to determine whether your prescription qualifies.

Coverage Eligibility and Effective Date

When Preexisting Condition Exclusion Period Applies

The provisions subjecting late enrollees and special enrollees to the preexisting condition exclusion period are hereby deleted and the following added in place thereof:

A preexisting condition exclusion period applies if the member has a preexisting condition and:

- The plan member is a new employee and applies for coverage when initially eligible to enroll.

Duration of Exclusion Period

The preexisting condition exclusion period is:

- For a new employee who applies for coverage when initially eligible, 11 consecutive months, minus any period of prior creditable coverage.

Claims

Submitting Claims

Under When to File a Claim*, this provision revises the timeframe for you to submit claims.*

Effective April 1, 2008, Wellmark must receive claims within 365 days following the date of service of the claim.

General Provisions

The following provisions are added.

Member Health Support Services

Wellmark may from time to time make available to you certain health support services (such as disease management), for a fee or for no fee. Wellmark may offer financial and other incentives to you to use such services. As a part of the provision of these services, Wellmark may:

- Use your personal health information (including, but not limited to, substance abuse, mental health, and HIV/AIDS information); and
- Disclose such information to your health care providers and Wellmark's health support service vendors, for purposes of providing such services to you.

Wellmark will use and disclose information according to the terms of our Privacy Practices Notice, which is available upon request or at *www.wellmark.com*.

Value Added or Innovative Benefits

Wellmark may, from time to time, make available to you certain value added or innovative benefits for a fee or for no fee. Examples include discounts on alternative/preventive therapies, fitness, exercise and diet assistance, and elective procedures as well as resources to help you make more informed health decisions.

Glossary

The following definition is added, and these terms are deleted: Billed Charge, Covered Charge, *and* Settlement Amount.

Amount Charged. The amount that a provider bills for a service or supply or the retail price that a pharmacy charges for a prescription drug, whether or not it is covered under this group health plan.

(Also see *Payment Arrangements* under *Factors Affecting What You Pay* earlier in this amendment.)

All other terms and provisions of your benefit booklet, including any amendments we may have issued previously, remain unaltered and in effect.

David N. Southwell
Group Vice President, Financial Officer and Treasurer
Wellmark Blue Cross and Blue Shield of Iowa;
Treasurer, Wellmark Health Plan of Iowa, Inc.

Wellmark BlueCross BlueShield of Iowa
Wellmark Health Plan of Iowa, Inc.

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Amendment to Your Benefit Booklet

This amendment changes the descriptions of other coverage, rules of coordination, and coordinating benefits for dependent children in the *Coordination of Benefits* section of your benefit booklet, effective January 25, 2007. Please review the amendment and keep it with your benefit booklet.

Please note: Certain provisions apply only if you have either Blue Rx Preferred drug coverage or Blue Dental coverage. References to these coverage plans do not provide any additional coverage that you do not already have.

Coordination of Benefits

Coordination of benefits applies when you have more than one insurance policy or plan that provides the same or similar benefits as this plan. Benefits payable under this plan, when combined with those paid under your other coverage, will not be more than 100 percent of either our payment arrangement amount or the other plan's payment arrangement amount.

Other Coverage

When you receive services, you must inform us that you have other coverage, and inform your health care provider about your other coverage. Other coverage includes any of the following:

- Group and nongroup insurance contracts and subscriber contracts.
- HMO contracts.
- Uninsured arrangements of group or group-type coverage.
- Group and nongroup coverage through closed panel plans.
- Group-type contracts.
- The medical care components of long-term contracts, such as skilled nursing care.
- Medicare or other governmental benefits (not including Medicaid).
- The medical benefits coverage of your auto insurance (whether issued on a fault or no-fault basis).

Coverage that is not subject to coordination of benefits includes the following:

- Hospital indemnity coverage or other fixed indemnity coverage.
- Accident-only coverage.
- Specified disease or specified accident coverage.
- Limited benefit health coverage, as defined by Iowa law.
- School accident-type coverage.
- Benefits for non-medical components of long-term care policies.
- Medicare supplement policies.
- Medicaid policies.
- Coverage under other governmental plans, unless permitted by law.

You must cooperate with Wellmark and provide requested information about other coverage. Failure to provide information can result in a denied claim. We may get the facts we need from or give them to other organizations or persons for the purpose of applying the following rules and determining the benefits payable under this plan and other plans covering you. We need not tell, or get the consent of, any person to do this.

Rules of Coordination

We follow certain rules to determine which health plan or coverage pays first (as the primary plan) when other coverage provides the same or similar benefits as this group health plan. Here are some of those rules:

- The primary plan pays or provides benefits according to its terms of coverage and without regard to the benefits under any other plan. Except as provided below, a plan that does not contain a coordination of benefits provision that is consistent with applicable regulations is always primary unless the provisions of both plans state that the complying plan is primary.
- Coverage that is obtained by membership in a group and is designed to supplement a part of a basic package of benefits is excess to any other parts of the plan provided by the contract holder. (Examples of such supplementary coverage are major medical coverage that is superimposed over base plan hospital and surgical benefits and insurance-type coverage written in connection with a closed panel plan to provide out-of-network benefits.)
- The coverage that you have as an employee, plan member, subscriber, policyholder or retiree pays before coverage that you have as a spouse or dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, plan member, subscriber, policyholder or retiree is the secondary plan and the other plan is the primary plan.
- The coverage that you have as the result of active employment (not laid off or retired) pays before coverage that you have as a laid-off or retired employee. The same would be true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, plan member, subscriber, policyholder or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- If you currently have dental coverage under Blue Dental, benefits for dental services under your medical benefits plan are payable before benefits under your Blue Dental benefits plan.
- Notwithstanding the preceding rules, if you currently have prescription drug coverage under Blue Rx Preferred, when you use your Blue Rx Preferred ID card, the benefits of your Blue Rx Preferred prescription drug plan are primary for prescription drugs purchased at a pharmacy.
- If the preceding rules do not determine the order of benefits, the benefits payable will be shared equally between the plans. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Dependent Children
To coordinate benefits for a dependent child, the following rules apply (unless there is a court decree stating otherwise):

- If the child is covered by both parents who are not married (and not separated) or who are living together, whether or not they have been married, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- For a child covered by separated or divorced parents or parents who are not living together, whether or not they have been married:
  - If a court decree states that one of the parents is responsible for the child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, then that parent's coverage pays first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's coverage pays first. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
  - If a court decree states that both parents are responsible for the child's health care expense or health care coverage or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
  - If a court decree does not specify which parent has financial or insurance responsibility, then the coverage of the parent with custody pays first. The payment order for the child is as follows: custodial parent, spouse of custodial parent, other parent, spouse of other parent. A custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

Wellmark follows the Iowa Insurance Division's Coordination of Benefits rules to determine our settlement amount. As a result, if none of these rules apply to your situation, we will use the Iowa Insurance Division's Coordination of Benefits rules to determine our settlement amount.

Effects on the Benefits of this Plan
When this plan is secondary, we may reduce its benefits so that total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other coverage and apply the calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan will credit to its applicable deductible any amounts it would have credited to its deductible in the absence of other coverage.

Right of Recovery
If the amount of payments made by us is more than we should have paid under these coordination of benefits provisions, we may recover the excess from any of the persons to or for whom we paid, or from any other person or organization that may be responsible for the benefits or services provided for the covered person. The amount of payments made includes the reasonable cash value of any benefits provided in the form of services.

All other terms and provisions of your benefit booklet, including any amendments we may have issued previously, remain unaltered and in effect.

David N. Southwell
Group Vice President, Financial Officer and Treasurer
Wellmark Blue Cross and Blue Shield of Iowa;
Treasurer, Wellmark Health Plan of Iowa, Inc.

Contents

About This Benefit Booklet

Contract

This benefit booklet describes your rights and responsibilities under your group health plan. You and your covered dependents have the right to request a copy of this benefit booklet, at no cost to you, by contacting your employer or group sponsor.

Please note: Your employer or group sponsor has the authority to terminate, amend, or modify the coverage described in this benefit booklet at any time. Any amendment or modification will be in writing and will be as binding as this benefit booklet. If your contract is terminated, you may not receive benefits.

You should familiarize yourself with the entire manual because it describes your benefits, payment obligations, provider networks, claim processes, and other rights and responsibilities.

Charts

Some sections have charts, which provide a quick reference or summary but are not a complete description of all details about a topic. A particular chart may not describe some significant factors that would help determine your coverage, payments, or other responsibilities. It is important for you to look up details and not to rely only upon a chart. It is also important to follow any references to other parts of the manual. (References tell you to "see" a section or subject heading, such as, "See *Details – Covered and Not Covered*." References may also include a page number.)

Complete Information

Very often, complete information on a subject requires you to consult more than one section of the manual. For instance, most information on coverage will be found in these sections:

- At a Glance – Covered and Not Covered
- Details – Covered and Not Covered
- General Conditions of Coverage, Exclusions, and Limitations

However, coverage might be affected also by your choice of provider (information in the *Choosing a Provider* section), certain notification requirements if applicable to your group health plan (the *Notification Requirements and Care Coordination* section), and considerations of eligibility or preexisting conditions (the *Coverage Eligibility and Effective Date* section).

Even if a service is listed as covered, benefits might not be available in certain situations, and even if a service is not specifically described as being excluded, it might not be covered.

Read Thoroughly

You can use your group health plan to the best advantage by learning how this document is organized and how sections are related to each other. And whenever you look up a particular topic, follow any references, and read thoroughly.

Your coverage includes many services, treatments, supplies, devices and drugs. Throughout the benefit booklet, the words *services or supplies* refer to any services, treatments, supplies, devices, or drugs, as applicable in the context, that may be used to diagnose or treat a condition.

Questions

If you have questions about your group health plan, or are unsure whether a particular service or supply is covered, call the Customer Service number on your ID card.

1. What You Pay

This section is intended to provide you with an overview of your payment obligations under this group health plan. This section is not intended to be and does not constitute a complete description of your payment obligations. To understand your complete payment obligations you must become familiar with this entire benefit booklet, especially the *Factors Affecting What You Pay* and *Choosing a Provider* sections.

Payment Summary

This chart summarizes your payment responsibilities. It is only intended to provide you with an overview of your payment obligations. It is important that you read this entire section and not just rely on this chart for your payment obligations.

Program 3 Plus

Category	You Pay
Inpatient Deductible	
	$300 per single contract **$400** (maximum) per family contract*
Office Visit Copayment	
	$15
Coinsurance	
	20%
Out-of-Pocket Maximum	
	$600 per single contract **$800** (maximum) per family contract*

*Family amounts are reached from amounts accumulated on behalf of any family member or combination of family members. You must satisfy the entire family deductible before we make benefit payments.

Blue Rx Preferred

Category	You Pay
Copayment	
	$5 for Tier 1 medications (most generic drugs). **$15** for Tier 2 medications (selected brand name and branded generic drugs). **$30** for Tier 3 medications (other brand name drugs). For more information see *Tiers*, page 46.
Out-of-Pocket Maximum	
	$250 per person **$500** per family*

*Family amounts are reached from amounts accumulated on behalf of any combination of family members.

Quantity Limits and Multiple Copayments

Generally, there is a maximum quantity of medication you may receive in a single prescription. Your payment obligations may be determined by the quantity of medication you purchase:

	Quantity Limit*	Payment
Retail Drugs	**30**-day supply	**1** copayment(s)
Retail Maintenance Drugs	**30**-day supply	**1** copayment(s)
Mail Order Maintenance Drugs	**90**-day supply	**2** copayment(s)

*Federal regulations limit the quantity that may be dispensed for certain medications. If your prescription is so regulated, it may not be available in the amount(s) indicated.

Payment Details

Program 3 Plus

Deductible

Inpatient Deductible. This is the fixed dollar amount you pay during a benefit year for inpatient services when you are admitted as an inpatient of a facility.

The family deductible amount is reached from amounts accumulated on behalf of any family member or combination of family members. You must satisfy the entire family deductible before we make benefit payments.

Once you meet the deductible, then coinsurance applies.

Common Accident Deductible. When two or more covered family members are involved in the same accident and they receive covered services for injuries related to the accident, only one deductible amount per person will be applied to the accident-related services for all family members involved. However, you still need to satisfy the family (not the per person) out-of-pocket maximum.

Deductible amounts are waived for some services. See *Waived Payment Obligations* later in this section.

Prior Deductible Credit. When you are covered by another State of Iowa health care plan administered by Wellmark Blue Cross and Blue Shield of Iowa immediately before becoming covered under this plan, any deductible amounts from the previous plan may be applied to help you meet the deductible under this plan. This is true when your coverage under both plans are for the same benefit year.

Copayment

This is a fixed dollar amount that you pay each time you receive certain covered services.

Office Visit Copayment.

$15 per person per visit.

The office visit copayment:

- applies to the office exam only.
- is taken once per date of service.

Related office services are subject to deductible and coinsurance and not this copayment.

Coinsurance

Coinsurance is an amount you pay for certain covered services. Coinsurance is calculated by multiplying the fixed percentage(s) shown earlier in this section times Wellmark's payment arrangement amount. Payment arrangements may differ depending on the contracting status of the provider and/or the state where you receive services. For details, see *How Coinsurance is Calculated*, page 43. Coinsurance

amounts apply after you meet the deductible.

Coinsurance amounts are waived for some services. See *Waived Payment Obligations* later in this section.

Out-of-Pocket Maximum

The out-of-pocket maximum is the maximum amount you pay, out of your pocket, for most covered services in a benefit year. Many amounts you pay for covered services during a benefit year accumulate toward the out-of-pocket maximum. These amounts include:

- Deductible.
- Coinsurance.

The family out-of-pocket maximum is reached from applicable amounts paid on behalf of any family member or combination of family members.

However, certain amounts do not apply toward your out-of-pocket maximum.

- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 29.
- Office visit copayments.

These amounts continue even after you have met your out-of-pocket maximum.

Lifetime Benefits Maximum

This is the maximum payment amount each member is eligible to receive for certain covered services in his or her lifetime.

Lifetime benefits maximum amounts are accumulated from claim payment amounts under this medical benefits plan and prior medical benefits plans sponsored by the State of Iowa and administered by Wellmark Blue Cross and Blue Shield of Iowa.

Waived Payment Obligations

Some payment obligations are waived for certain covered services.

Covered Service	Payment Obligation Waived
Accident care received in an office or the outpatient department of a facility. Care must be received within 72 hours of the injury.	Coinsurance
Emergency care received in the outpatient department of a facility, emergency room department of a facility, or admission following an emergency room visit.	Coinsurance
Newborn's initial hospitalization – facility and practitioner services for the first six days.	Inpatient Deductible Coinsurance
Office and outpatient surgery and related x-ray and lab services.	Coinsurance
Postpartum home visit (one) when a mother and her baby are voluntarily discharged from the hospital within 48 hours of normal labor and delivery or within 96 hours of cesarean birth.	Coinsurance
Services subject to office visit copayment amounts.	Coinsurance

Blue Rx Preferred

Copayment

Copayment is a fixed dollar amount you pay each time a covered prescription is filled or refilled.

The copayment amount depends on the following:

- The Tier to which the drug is assigned.
- The quantity of the prescription.

Out-of-Pocket Maximum

The out-of-pocket maximum is the maximum you pay in a given benefit year toward the following amounts:

- Copayments.

The family out-of-pocket maximum is reached from applicable amounts paid on behalf of any combination of family members.

2. At a Glance - Covered and Not Covered

Your coverage provides benefits for many services and supplies. There are also services for which this coverage does not provide benefits. The following chart is provided for your convenience as a quick reference only. This chart is not intended to be and does not constitute a complete description of all coverage details and factors that determine whether a service is covered or not. All covered services are subject to the contract terms and conditions contained throughout this benefit booklet. Many of these terms and conditions are contained in *Details – Covered and Not Covered*, page 13. To fully understand which services are covered and which are not, you must become familiar with this entire benefit booklet. Please call us if you are unsure whether a particular service is covered or not.

The headings in this chart provide the following information:

Category. Service categories are listed alphabetically and are repeated, with additional detailed information, in *Details – Covered and Not Covered*.

Covered. The listed category is generally covered, but some restrictions may apply.

Not Covered. The listed category is generally not covered.

See Page. This column lists the page number in *Details – Covered and Not Covered* where there is further information about the category.

Service/Prescription Maximum. This column lists maximum benefit amounts that each member is eligible to receive per covered service, prescription, benefit year, or lifetime. Service maximums or prescription maximums that apply per benefit year or per lifetime are reached from claim payment amounts accumulated under this group health plan and any prior group health plans sponsored by your employer or group sponsor and administered by Wellmark Blue Cross and Blue Shield of Iowa.

Please note: Service maximums accumulate for medical and prescription drug benefits separately.

Program 3 Plus

Category	Covered	Not Covered	See Page	Service Maximum
Acupuncture Treatment		⦸	13	
Allergy Testing and Treatment	●		13	
Ambulance Services	●		13	
Anesthesia	●		13	
Blood and Blood Administration	●		13	
Chemical Dependency Treatment	●		13	60 days for inpatient treatment per benefit year. This limit also includes mental health services.
Chemotherapy and Radiation Therapy	●		14	
Cosmetic Services		⦸	14	

Category	Covered	Not Covered	See Page	Service Maximum
Counseling Services		⦸	14	
Dental Services	●		14	
Dialysis	●		14	
Education Services for Diabetes	●		14	
Emergency Services	●		15	
Fertility and Infertility Services	●		15	$25,000 per couple for covered services and supplies related to infertility treatment per lifetime. This maximum accumulates from covered services received on or after **8/1/95.**
Genetic Testing	●		15	
Hearing Services	●		15	
Home Health Services	●		16	
Home/Durable Medical Equipment	●		16	
Hospice Services	●		17	15 days of inpatient hospice respite care per lifetime. 15 days of outpatient hospice respite care per lifetime. **Please note:** Hospice respite care must be used in increments of not more than five days at a time.
Hospitals and Facilities	●		17	
Illness or Injury Services	●		17	
Inhalation Therapy	●		18	
Maternity Services	●		18	
Medical and Surgical Supplies	●		18	
Mental Health Services	●		18	60 days for inpatient treatment per benefit year. This limit also includes chemical dependency services.
Morbid Obesity Treatment	●		19	
Motor Vehicles		⦸	20	
Musculoskeletal Treatment	●		20	
Nonmedical Services		⦸	20	
Occupational Therapy	●		20	
Orthotics		⦸	20	
Personal Convenience Items		⦸	20	
Physical Therapy	●		20	
Physicians and Practitioners			21	
Advanced Registered Nurse Practitioners	●		21	
Chiropractors	●		21	
Doctors of Osteopathy	●		21	
Licensed Independent Social Workers	●		21	

Category	Covered	Not Covered	See Page	Service Maximum
Medical Doctors	●		21	
Occupational Therapists	●		21	
Optometrists	●		21	
Oral Surgeons	●		21	
Physical Therapists	●		21	
Physician Assistants	●		21	
Podiatrists	●		21	
Psychologists	●		21	
Prescription Drugs	●		21	
Preventive Care	●		22	Well-child care until the child reaches age seven. One routine physical examination per benefit year. One routine mammogram per benefit year.
Prosthetic Appliances	●		22	
Reconstructive Surgery	●		23	
Self Help Programs		⦸	23	
Sleep Apnea Treatment	●		23	
Speech Therapy	●		23	
Surgery	●		23	
Temporomandibular Joint Disorder (TMD)	●		23	
Transplants	●		24	$10,000 per operation for costs associated with a member's transportation in an ambulance to a transplant center. $20,000 per operation for costs associated with organ procurement of cadaveric organ, even if more than one organ is transplanted. $20,000 per bone marrow/stem cell transfer for costs associated with a donor search.
Travel or Lodging Costs		⦸	24	
Vision Services	●		24	
Wigs or Hair Pieces		⦸	24	
X-ray and Laboratory Services	●		25	

Blue Rx Preferred

Prescription Drug Category	Covered	Not Covered	See Page	Prescription Maximum
Branded Generic Prescription Drugs	●		26	Mail Order Maintenance Prescriptions a 90-day supply. Retail Maintenance Prescriptions a 30-day supply. Retail Non-Maintenance Prescriptions a 30-day supply.
Brand Name Prescription Drugs	●		26	Mail Order Maintenance Prescriptions a 90-day supply. Retail Maintenance Prescriptions a 30-day supply. Retail Non-Maintenance Prescriptions a 30-day supply.
Chemical Dependency Drugs	●		26	
Contraceptives	●		26	
Convenience Packaging		⦸	26	
Cosmetic Drugs		⦸	26	
Drugs that are Lost, Damaged, Stolen, or Used Inappropriately		⦸	26	
Drugs You Abuse		⦸	27	
Generic Prescription Drugs	●		27	Mail Order Maintenance Prescriptions a 90-day supply. Retail Maintenance Prescriptions a 30-day supply. Retail Non-Maintenance Prescriptions a 30-day supply.
Immunization Agents		⦸	27	
Impotence Drugs	●		27	
Infertility Drugs		⦸	27	
Insulin and Supplies	●		27	
Irrigation Solutions and Supplies		⦸	27	
Nutritional and Dietary Supplements	●		27	
Over-the-Counter Products		⦸	27	
Self-Administered Injectable Drugs	●		27	
Self-Help Drugs		⦸	27	
Therapeutic Devices or Medical Appliances		⦸	28	
Tobacco Dependency Drugs		⦸	28	

Prescription Drug Category	Covered	Not Covered	See Page	Prescription Maximum
Weight Reduction Drugs		⊘	28	

3. Details - Covered and Not Covered

All covered services or supplies listed in this section are subject to the general contract provisions and limitations described in this benefit booklet. Also see the section *General Conditions of Coverage, Exclusions, and Limitations*, page 29. If a service or supply is not specifically listed, do not assume it is covered.

Program 3 Plus

Acupuncture Treatment

Not Covered: Acupuncture and acupressure treatment.

Allergy Testing and Treatment

Covered.

Ambulance Services

Covered: Professional air and ground ambulance transportation to a hospital or nursing facility in the surrounding area where your ambulance transportation originates.

All of the following are required to qualify for benefits:

- No other method of transportation is appropriate.
- The services required to treat your illness or injury are not available in the facility where you are currently receiving care if you are an inpatient at a facility.
- You are transported to the nearest hospital or nursing facility with adequate facilities to treat your medical condition.

See Also:

Transplants later in this section.

Anesthesia

Covered: Anesthesia and the administration of anesthesia.

Not Covered: Local or topical anesthesia billed separately from related surgical or medical procedures.

Blood and Blood Administration

Covered: Blood and blood administration.

Chemical Dependency Treatment

Covered: Inpatient or office/outpatient treatment for a condition with physical or psychological symptoms produced by the habitual use of certain drugs as described in the most current *Diagnostic and Statistical Manual of Mental Disorders*.

Service Maximum:

- **60 days** for inpatient treatment per benefit year. This limit also includes mental health services.

Not Covered:

- Residential treatment of mental health conditions or chemical dependency that meets the following criteria:
  - treatment is provided in a 24-hour residential setting,
  - treatment is for severe, persistent, or chronic mental health conditions or chemical dependency,
  - treatment involves therapeutic intervention and specialized programming with a high degree of structure and supervision,
  - treatment includes training in basic skills such as social skills and activities of daily living, and
  - treatment does not require daily supervision of a physician.

See Also:

Hospitals and Facilities later in this section.

Blue Rx Preferred, page 26.

Chemotherapy and Radiation Therapy

Covered: Use of chemical agents or radiation to treat or control a serious illness.

Cosmetic Services

Not Covered: Cosmetic services, supplies, or drugs unless provided primarily to restore function lost or impaired as the result of an illness, accidental injury, or a birth defect including treatment for any complications resulting from a noncovered cosmetic procedure.

See Also:

Reconstructive Surgery later in this section.

Counseling Services

Not Covered: Bereavement counseling or services (including volunteers or clergy), family counseling or training services, and marriage counseling or training services.

See Also:

Genetic Testing later in this section.

Mental Health Services later in this section.

Dental Services

Covered:

- Dental treatment for accidental injuries when all of the following requirements are met:
  - Treatment is completed within six months of the injury.
- Anesthesia (general) and hospital or ambulatory surgical facility services related to covered dental services if:
  - You are under age 14 and, based on a determination by a licensed dentist and your treating physician, you have a dental or developmental condition for which patient management in the dental office has been ineffective and requires dental treatment in a hospital or ambulatory surgical facility; or
  - Based on a determination by a licensed dentist and your treating physician, you have one or more medical conditions that would create significant or undue medical risk in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical facility.
- Impacted teeth removal (surgical) as an outpatient. Inpatient removal is covered only when you have a medical condition (such as hemophilia) that requires hospitalization.
- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands, or ducts.
- Jaw dislocation manipulation.
- Treatment of abnormal changes in the mouth due to injury or disease.

Not Covered:

- General dentistry including, but not limited to, diagnostic and preventive services, restorative services, endodontic services, periodontal services, cast restorations, dentures and bridges, and orthodontic services.
- Injuries associated with or resulting from the act of chewing.
- Maxillary or mandibular tooth implants (osseointegration).

Dialysis

Covered: Removal of toxic substances from the blood when the kidneys are unable to do so when provided as an inpatient in a hospital setting or as an outpatient in a Medicare-approved dialysis center.

Education Services for Diabetes

Covered: Outpatient diabetes education that helps a member with any type of diabetes mellitus and his or her family

understand the diabetes disease process and the daily management of diabetes. You must receive diabetes education from a state-approved, outpatient education program.

See Also:

Blue Rx Preferred, page 26.

Emergency Services

Covered: Services provided in an emergency room setting when treatment is for a medical condition manifested by acute symptoms of sufficient severity, including pain, that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy; or
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

In an emergency situation, if you cannot reasonably reach a participating provider, covered services will be reimbursed as though they were received from a participating provider.

Fertility and Infertility Services

Covered:

- Fertility prevention, such as tubal ligation (or its equivalent) or vasectomy (initial surgery only).
- Infertility testing and treatment including in vitro fertilization, gamete intrafallopian transfer (GIFT), and pronuclear stage transfer (PROST).
- Infertility treatment related to the collection or purchase of donor semen (sperm) or oocytes (eggs); freezing of sperm, oocytes, or embryos; surrogate parent medical services.

Service Maximum:

- **$25,000** per couple for covered services and supplies related to infertility treatment per lifetime. This maximum accumulates from covered services received on or after **8/1/95.**

Not Covered:

- Infertility treatment if the infertility is the result of voluntary sterilization.
- Nonmedical services of a surrogate parent.
- Reversal of a tubal ligation (or its equivalent) or vasectomy.

See Also:

Blue Rx Preferred, page 26.

Prior Approval, page 38.

Genetic Testing

Covered: Genetic molecular testing (specific gene identification) and related counseling are covered when both of the following requirements are met:

- You are an appropriate candidate for a test under medically recognized standards (for example, family background, past diagnosis, etc.).
- The outcome of the test is expected to determine a covered course of treatment or prevention and is not merely informational.

See Also:

Prior Approval, page 38.

Hearing Services

Covered:

- Hearing examinations, but only to test or treat hearing loss related to an illness or injury.

Not Covered:

- Hearing aids.
- Routine hearing examinations.

Home Health Services

Covered: All of the following requirements must be met in order for home health services to be covered:

- You require a medically necessary skilled service such as skilled nursing, physical therapy, or speech therapy.
- Services are received from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) and/or a Medicare-certified agency.
- Services are prescribed by a physician and approved by our case manager for the treatment of illness or injury when you are homebound.
- Services are not more costly than alternative services that would be effective for diagnosis and treatment of your condition.
- The care is prescribed by a physician and approved by a Wellmark case manager.

The following are covered services and supplies:

Home Health Aide Services—when provided in conjunction with a medically necessary skilled service also received in the home.

Home Skilled Nursing. Treatment must be given by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) from an agency accredited by the Joint Commission for Accreditation of Health Care Organizations (JCAHO) or a Medicare-certified agency. Reimbursement will not exceed the amount we would provide for a comparable level of care in a facility setting, and skilled nursing visits will be coordinated by a case manager.

Inhalation Therapy.

Medical Equipment.

Medical Social Services.

Medical Supplies.

Occupational Therapy—but only for services to treat the upper extremities, which means the arms from the shoulders to the fingers. You are not covered for occupational therapy supplies.

Oxygen and Equipment for its administration.

Parenteral and Enteral Nutrition.

Physical Therapy.

Prescription Drugs and Medicines administered in the vein or muscle.

Prosthetic Appliances and Braces.

Speech Therapy.

Not Covered: Custodial home care services and supplies, which help you with your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding, and other forms of assistance with normal bodily functions; preparation of special diets; and supervision of medication that can usually be self-administered. You are also not covered for sanitaria care or rest cures.

See Also:

Case Management, page 39.

Precertification, page 37.

Home/Durable Medical Equipment

Covered: Equipment that meets the following requirements:

- Durable enough to withstand repeated use.
- Primarily and customarily manufactured to serve a medical purpose.
- Not useful in the absence of illness or injury.

In addition, we determine whether to pay the rental amount or the purchase price amount for an item, and we determine the length of any rental term. Benefits will never exceed the lesser of the billed charge or the maximum allowable fee.

See Also:

Medical and Surgical Supplies later in this section.

Orthotics later in this section.

Personal Convenience Items later in this section.

Prosthetic Appliances later in this section.

Prior Approval, page 38.

Hospice Services

Covered: Care (generally in a home setting) for patients who are terminally ill and who have a life expectancy of six months or less. Hospice care covers the same services as described under *Home Health Services*, as well as hospice respite care from a facility approved by Medicare or by the Joint Commission for Accreditation of Health Care Organizations (JCAHO).

Hospice respite care offers rest and relief help for the family caring for a terminally ill patient. Inpatient respite care can take place in a nursing home, nursing facility, or hospital. Hospice respite care must be used in increments of not more than five days at a time. Hospice care must be precertified.

Service Maximum:

- **15 days** of inpatient hospice respite care per lifetime.
- **15 days** of outpatient hospice respite care per lifetime.

Please note: Hospice respite care must be used in increments of not more than five days at a time.

See Also:

Precertification, page 37.

Hospitals and Facilities

Covered: Hospitals and other facilities that meet standards of licensing, accreditation or certification. Following are some recognized facilities:

Ambulatory Surgical Facility. This type of facility provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient hospital bed.

Chemical Dependency Treatment Facility. This type of facility provides treatment of chemical dependency and must be licensed and approved by Wellmark.

Community Mental Health Center. This type of facility provides outpatient treatment of mental health conditions and must be licensed and approved by Wellmark.

Hospital. This type of facility provides for the diagnosis, treatment, or care of injured or sick persons on an inpatient and outpatient basis. The facility must be licensed as a hospital under applicable law.

Nursing Facility. This type of facility provides continuous skilled nursing services as ordered and certified by your attending physician on an inpatient basis. A registered nurse (R.N.) must supervise services and supplies on a 24-hour basis. The facility must be licensed as a nursing facility under applicable law.

Illness or Injury Services

Covered: Services or supplies used to treat any bodily disorder, bodily injury, disease, or mental health condition unless specifically addressed elsewhere in this section. This includes pregnancy and complications of pregnancy.

Treatment may be received from an approved provider in any of the following settings:

- Home.
- Inpatient (such as a hospital or nursing facility).
- Office (such as a doctor's office).
- Outpatient.

See Also:

Precertification, page 37.

Inhalation Therapy

Covered: Respiratory or breathing treatments to help restore or improve breathing function.

Maternity Services

Covered: Prenatal and postnatal care, delivery, including complications of pregnancy. A complication of pregnancy refers to a cesarean section that was not planned, an ectopic pregnancy that is terminated, or a spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible. Complications of pregnancy also include conditions requiring inpatient hospital admission (when pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy.

In accordance with federal or applicable state law, maternity services include a minimum of:

- 48 hours of inpatient care (in addition to the day of delivery care) following a vaginal delivery, or
- 96 hours of inpatient care (in addition to the day of delivery) following a cesarean section.

A practitioner is not required to seek Wellmark's review in order to prescribe a length of stay of less than 48 or 96 hours. The attending practitioner, in consultation with the mother, may discharge the mother or newborn prior to 48 or 96 hours, as applicable.

If the inpatient hospital stay is shorter, coverage includes a follow-up postpartum home visit by a registered nurse (R.N.). This nurse must be from a home health agency under contract with Wellmark or employed by the delivering physician.

See Also:

Coverage Change Events, page 55.

Medical and Surgical Supplies

Covered: Medical supplies and devices such as:

- Dressings and casts.
- Oxygen and equipment needed to administer the oxygen.

Not Covered:

- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.
- Insulin syringes or supplies.

See Also:

Home/Durable Medical Equipment earlier in this section.

Orthotics later in this section.

Blue Rx Preferred, page 26.

Personal Convenience Items later in this section.

Prosthetic Appliances later in this section.

Mental Health Services

Covered: Treatment for certain psychiatric, psychological, or emotional conditions as an inpatient or outpatient. Recognized facilities for mental health services include licensed and accredited community mental health centers that provide mental health services on an outpatient basis.

Coverage includes diagnosis and treatment of these biologically based mental illnesses:

- Schizophrenia.
- Bipolar disorders.
- Major depressive disorders.
- Schizo-affective disorders.
- Obsessive-compulsive disorders.
- Pervasive developmental disorders.
- Autistic disorders.

To qualify for mental health treatment benefits, the following requirements must be met:

- The disorder is listed only as a mental health condition in the most current "International Classification of Diseases, Ninth Revision, Clinical Modification" (ICD-9-CM) and not dually listed elsewhere in the ICD-9-CM.
- The disorder is not a chemical dependency condition.

Please note: Your employer's Employee Assistance Program (EAP) may be able to provide counseling services for certain conditions. For more information, contact your EAP coordinator.

Service Maximum:

- **60 days** for inpatient treatment per benefit year. This limit also includes chemical dependency services.

Not Covered:

- Certain disorders related to early childhood, such as academic underachievement disorder.
- Communication disorders, such as stuttering and stammering.
- Impulse control disorders, such as pathological gambling.
- Nicotine dependence.
- Nonpervasive developmental and learning disorders.
- Sensitivity, shyness, and social withdrawal disorders.
- Sexual identification or gender disorders.
- Residential treatment of mental health conditions or chemical dependency that meets the following criteria:
  - treatment is provided in a 24-hour residential setting,
  - treatment is for severe, persistent, or chronic mental health conditions or chemical dependency,
  - treatment involves therapeutic intervention and specialized programming with a high degree of structure and supervision,
  - treatment includes training in basic skills such as social skills and activities of daily living, and
  - treatment does not require daily supervision of a physician.

See Also:

Hospitals and Facilities earlier in this section.

Morbid Obesity Treatment

Covered: Weight reduction surgery provided you are at least 18 years of age and an appropriate surgical candidate under the following requirements:

- You have a Body Mass Index of:
  - at least 40 for at least three years, or
  - at least 50 (classified as super-obese), or
  - greater than 35 in conjunction with documented treatment of a coexisting medical condition of at least one of the following:
    - hypertension requiring medication for at least one year,
    - type 2 diabetes requiring medication for at least one year,
    - obstructive sleep apnea, confirmed by a sleep study, which does not respond to conservative treatment,
    - cardiovascular disease, or
    - pulmonary hypertension of obesity.

- You have a documented history of failure to sustain weight loss with medically supervised dietary and conservative treatment for at least three years, including within two years before surgery.
- You are an acceptable operative risk.
- You have been evaluated by a licensed mental health provider who documents that you are motivated to follow all necessary pre- and post-operative treatment plans.

Not Covered:

- Weight reduction programs or supplies (including dietary supplements, foods, equipment, lab testing, examinations, and prescription drugs), whether or not weight reduction is medically appropriate.

See Also:

Prior Approval, page 38.

Motor Vehicles

Not Covered: Purchase or rental of motor vehicles such as cars or vans. You are also not covered for equipment or costs associated with converting a motor vehicle to accommodate a disability.

Musculoskeletal Treatment

Covered: Outpatient nonsurgical treatment of ailments related to the musculoskeletal system, such as manipulations or related procedures to treat musculoskeletal injury or disease.

Not Covered: Massage therapy.

Nonmedical Services

Not Covered: Such services as telephone consultations, charges for failure to keep scheduled appointments, charges for completion of any form, charges for medical information, and educational or recreational therapy or services or supplies that are nonmedical.

Occupational Therapy

Covered: Services are covered, but only those services to treat the upper extremities, which means the arms from the shoulders to the fingers.

Not Covered:

- Occupational therapy supplies.
- Services or supplies provided primarily for diagnostic evaluations, physical therapy, or occupational therapy as an inpatient.

Orthotics

Not Covered: Orthotic foot devices such as arch supports or in-shoe supports, orthopedic shoes, elastic supports, or examinations to prescribe or fit such foot devices, supports, or shoes.

See Also:

Home/Durable Medical Equipment earlier in this section.

Personal Convenience Items later in this section.

Prosthetic Appliances later in this section.

Personal Convenience Items

Not Covered: Supplies or devices that are useful or convenient in the absence of illness or injury (for example, air conditioners, dehumidifiers, ramps, home remodeling, hot tubs, and swimming pools).

Physical Therapy

Covered.

Not Covered: Services or supplies provided as an inpatient that are primarily for diagnostic evaluations, physical therapy, or occupational therapy.

Physicians and Practitioners

Covered: Most services provided by practitioners that are recognized by us and meet standards of licensing, accreditation or certification. Following are some recognized physicians and practitioners:

Advanced Registered Nurse Practitioners (ARNP). This provider is a registered nurse with advanced training in a specialty area who is registered with the Iowa Board of Nursing to practice in an advanced role. Specialty designations include: certified clinical nurse specialists, certified nurse midwives, certified nurse practitioners, and certified registered nurse anesthetists. An ARNP may provide care as an independent practitioner or in collaboration or consultation with a physician.

Chiropractors.

Doctors of Osteopathy (D.O.).

Licensed Independent Social Workers.

Medical Doctors (M.D.).

Occupational Therapists. This provider is covered only when treating the upper extremities, which means the arms from the shoulders to the fingers.

Optometrists. This provider diagnoses and treats eye health and vision problems. Optometrists prescribe glasses, contact lenses, low vision rehabilitation, vision therapy, and prescription drugs and medications as well as perform certain surgical procedures. This provider holds a doctor of optometry (O.D.) degree.

Oral Surgeons. This provider is a dentist licensed to perform diagnosis and treatment of oral conditions requiring surgical intervention.

Physical Therapists.

Physician Assistants. This provider is licensed by the Board of Physician Assistant Examiners to provide care under the supervision of a physician.

Podiatrists. These providers are specialists in conditions of the feet.

Psychologists. Wellmark recognizes this type of provider as a *health service provider in psychology*. However, this provider will be referred to as a psychologist in this document. Psychologists have a doctorate degree in psychology with two years' clinical experience and who meets the standards of a national register.

Not Covered:

- Athletic Trainers.

See Also:

Choosing a Provider, page 33.

Prescription Drugs

Covered: Most prescription drugs and medicines that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription," are generally covered under Blue Rx Preferred, your prescription drug plan and not under this medical benefits plan. However, there are exceptions when prescription drugs and medicines are covered under this medical benefits plan.

Additional prescription drugs and medicines covered under this medical benefits plan include:

Contraceptives. The following conception prevention, as approved by the U.S. Food and Drug Administration:

- Contraceptive devices.
- Implanted contraceptives.
- Injected contraceptives.

Drugs and Biologicals. Drugs and biologicals approved by the Food and Drug Administration. This includes such supplies as globulin, serum, vaccine, antitoxin, or antigen used in the prevention or treatment of disease.

Growth Hormones.

Infertility Prescription Drugs.

Intravenous Administration. Intravenous administration of nutrients, antibiotics, and other drugs and fluids when provided in the home (home infusion therapy).

Self-administered Injectable Drugs. Self-administered injectable drugs (except insulin, Imitrex, EpiPen, and Antikit which are benefits under your Blue Rx Preferred prescription drug plan and not this medical benefits plan).

Not Covered:

- Contraceptives absorbed through the skin.
- Insulin.
- Oral contraceptives.
- Prescription drugs and devices used to treat nicotine dependence, including related medical evaluations, psychotherapy, and x-ray and lab services.

See Also:

Blood and Blood Administration earlier in this section.

Blue Rx Preferred, page 26.

Prior Authorization, page 40.

Preventive Care

Covered:

- Immunizations.
- Mammograms.
- Pap smears.
- Physical examinations including a gynecological examination when performed during the physical examination.
- Well-child care including age-appropriate pediatric preventive services, as defined by current recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Service Maximum:

- Well-child care until the child reaches age seven.
- **One** routine physical examination per benefit year.
- **One** routine mammogram per benefit year.

Not Covered:

- Routine foot care, including related services or supplies.
- Periodic physicals or health examinations, screening procedures, or immunizations performed solely for school, sports, employment, insurance, licensing, or travel.

See Also:

Hearing Services earlier in this section.

Vision Services later in this section.

Prosthetic Appliances

Covered: Devices used as artificial substitutes to replace a missing natural part of the body or to improve, aid, or increase the performance of a natural function.

Also covered are braces, which are rigid or semi-rigid appliances and devices commonly used to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. Braces do not include elastic stockings, elastic bandages, garter belts, arch supports, orthodontic devices, or other similar items.

Not Covered:

- Devices such as eyeglasses, hearing aids, orthopedic shoes, arch supports, or

examinations for their prescription or fitting.
- Elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

See Also:

Home/Durable Medical Equipment earlier in this section.

Medical and Surgical Supplies earlier in this section.

Orthotics earlier in this section.

Personal Convenience Items earlier in this section.

Reconstructive Surgery

Covered: Reconstructive surgery primarily intended to restore function lost or impaired as the result of an illness, injury, or a birth defect (even if there is an incidental improvement in physical appearance) including breast reconstructive surgery following mastectomy. Breast reconstructive surgery includes the following:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses, and
- Treatment of physical complications of the mastectomy, including lymphedemas.

See Also:

Prior Approval, page 38.

Cosmetic Services earlier in this section.

Self Help Programs

Not Covered: Self-help and self-cure products or drugs.

Sleep Apnea Treatment

Covered: Obstructive sleep apnea diagnosis and treatments.

Not Covered: Treatment for snoring without a diagnosis of obstructive sleep apnea.

See Also:

Prior Approval, page 38.

Speech Therapy

Covered: Rehabilitative speech therapy treatment.

Not Covered:

- Speech therapy when services are provided outside of a facility or not coordinated through home health services.
- Speech therapy to treat certain developmental, learning, or communication disorders, such as stuttering and stammering.

See Also:

Prior Approval, page 38.

Surgery

Covered. This includes the following:

- Major endoscopic procedures.
- Operative and cutting procedures.
- Preoperative and postoperative care.

Not Covered:

- Surgical procedures to correct impotency.

See Also:

Dental Services earlier in this section.

Reconstructive Surgery earlier in this section.

Temporomandibular Joint Disorder (TMD)

Covered.

Not Covered: Dental extractions, dental restorations, or orthodontic treatment for temporomandibular joint disorders.

Transplants

Covered:

- Certain bone marrow/stem cell transfers from a living donor.
- Heart.
- Heart and lung.
- Kidney.
- Liver.
- Lung.
- Pancreas.
- Simultaneous pancreas/kidney.
- Small bowel.

Transplants are subject to Case Management.

Charges related to the donation of an organ are usually covered by the recipient's medical benefits plan. However, if donor charges are excluded by the recipient's plan, and you are a donor, the charges will be covered by this medical benefits plan.

In certain situations, the cost associated with organ procurement of cadaveric organs may be limited, even if more than one organ is transplanted. When this happens, the organ procurement limitation does not apply to organs donated by a living donor or cadaveric organ transplants received in a facility that agrees to accept a *global pricing arrangement*. *Global Pricing Arrangements* refers to an all-inclusive payment arrangement. This all-inclusive payment arrangement bundles costs into one charge which includes all costs for hospitalization and physician fees. For information about whether a facility accepts global pricing, call us at **800-552-3993**.

Service Maximum:

- **$10,000** per operation for costs associated with a member's transportation in an ambulance to a transplant center.
- **$20,000** per operation for costs associated with organ procurement of a cadaveric organ, even if more than one organ is transplanted.
- **$20,000** per bone marrow/stem cell transfer for costs associated with a donor search.

Not Covered:

- Expenses of transporting a living donor.
- Expenses related to the purchase of any organ.
- Services or supplies related to mechanical or non-human organs associated with transplants.
- Transplant services and supplies not listed in this section including complications and ambulance services.

See Also:

Prior Approval, page 38.

Case Management, page 39.

Travel or Lodging Costs

Not Covered.

Vision Services

Covered: Vision examinations but only when related to an illness or injury.

Not Covered:

- Treatment for a refractive error including surgery (i.e. when the shape of your eye does not bend light correctly resulting in blurred images).
- Eyeglasses or contact lenses, including charges related to their fitting.
- Eye exercises.
- Prescribing of corrective lenses.
- Eye examinations for the fitting of eyewear.
- Routine vision examinations.

Wigs or Hair Pieces

Not Covered.

X-ray and Laboratory Services

Covered: Tests, screenings, imagings, and evaluation procedures as identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

See Also:

Preventive Care earlier in this section.

Blue Rx Preferred

You are covered for most prescription drugs that bear the legend, "Caution, Federal Law prohibits dispensing without a prescription" and meet the following criteria:

- Prescribed by a practitioner who is legally authorized to prescribe.
- Dispensed by a recognized licensed retail pharmacy or through the mail order drug program.
- Drugs that are medically necessary for your condition. See *Medically Necessary*, page 29.

Covered drugs are limited to those taken orally, absorbed through the skin, and certain self-administered injected prescription drugs. Devices and implants are never covered.

Branded Generic Prescription Drugs

Covered: Branded generics that are substitute prescription drugs with the same active chemical ingredients as brand name drugs.

A branded generic may be treated as a brand name drug throughout the industry for one of the following reasons:

- It is not made under the original patent, but the manufacturer traditionally makes brand name drugs instead of generics; or
- The drug's price is not significantly lower than that of the brand name drug.

Prescription Maximum:

- Mail Order Maintenance Prescriptions. A 90-day supply.
- Retail Maintenance Prescriptions. A 30-day supply.
- Retail Non-Maintenance Prescriptions. A 30-day supply.

See Also:

Prior Authorization, page 40.

Brand Name Prescription Drugs

Covered: A prescription drug patented by the original manufacturer.

Prescription Maximum:

- Mail Order Maintenance Prescriptions. A 90-day supply.
- Retail Maintenance Prescriptions. A 30-day supply.
- Retail Non-Maintenance Prescriptions. A 30-day supply.

See Also:

Prior Authorization, page 40.

Chemical Dependency Drugs

Covered.

Contraceptives

Covered: Oral contraceptives and contraceptives absorbed through the skin.

Not Covered: Contraceptive devices and implants.

See Also:

Prescription Drugs, page 21.

Convenience Packaging

Not Covered: When the cost exceeds the cost of the drug when purchased in its normal container.

Cosmetic Drugs

Not Covered: Prescription drugs that are primarily to improve your natural appearance.

Drugs that are Lost, Damaged, Stolen, or Used Inappropriately

Not Covered.

Drugs You Abuse

Not Covered: Drugs determined to be abused or otherwise misused by you.

Generic Prescription Drugs

Covered: Prescription drugs with active therapeutic ingredients chemically identical to a brand name drug. These drugs are often available at a lower cost than their brand-name equivalent.

Prescription Maximum:

- Mail Order Maintenance Prescriptions. A 90-day supply.
- Retail Maintenance Prescriptions. A 30-day supply.
- Retail Non-Maintenance Prescriptions. A 30-day supply.

See Also:

Prior Authorization, page 40.

Immunization Agents

Not Covered: Drugs used as immunization agents or biological products for allergy immunization, or biological serum, blood, blood plasma, and other blood products or fractions.

See Also:

Prescription Drugs, page 21.

Impotence Drugs

Covered: If the condition is the result of a physical illness or injury.

Infertility Drugs

Not Covered: Prescription drugs necessary to treat male or female infertility.

See Also:

Prescription Drugs, page 21.

Insulin and Supplies

Covered: Insulin, needles, syringes, test strips, and lancets.

Irrigation Solutions and Supplies

Not Covered.

Nutritional and Dietary Supplements

Covered:

- Prenatal vitamins.

Not Covered: Nutritional or dietary supplements including, but not limited to:

- Special dietary formulas.
- Herbal products.
- Minerals.
- Supplementary vitamin preparations.
- Multivitamins.

Over-the-Counter Products

Not Covered: Most over-the-counter products, including nutritional dietary supplements. However, certain over-the-counter products prescribed by a physician may be covered. To determine if a particular over-the-counter product is covered, call the toll-free Customer Service number on your ID card.

Sales Tax

Covered: If you purchase a covered prescription drug that is subject to a state sales tax, the sales tax amount is covered.

Self-Administered Injectable Drugs

Covered: Insulin, Imitrex, EpiPen, and Antikit.

Not Covered: All other self-administered injectables.

See Also:

Prescription Drugs, page 21.

Self-Help Drugs

Not Covered: Self-help or self-cure products or drugs.

Therapeutic Devices or Medical Appliances

Not Covered: Therapeutic devices or medical appliances including hypodermic needles or syringes and home/durable medical equipment. This exclusion does not apply to needles and syringes for insulin.

See Also:

Prescription Drugs, page 21.

Tobacco Dependency Drugs

Not Covered.

Weight Reduction Drugs

Not Covered: Regardless of whether weight reduction is medically appropriate.

See Also:

Prescription Drugs, page 21.

Prescription Purchases Outside the United States

To qualify for benefits for prescription drugs purchased outside the United States, all of the following requirements must be met:

- You are injured or become ill while in a foreign country.
- The prescription drug is FDA-approved or an FDA equivalent and has the same name as the FDA-approved drug.
- The prescription drug would require a written prescription by a licensed practitioner if prescribed in the U.S.
- You provide acceptable documentation that you received a covered service from a practitioner or hospital and the practitioner or hospital prescribed the prescription drug.

Quantity Limitations

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription. In addition, benefits for certain drugs are limited by month, benefit period, or lifetime, based on Wellmark's medical necessity criteria. For a list of these limited drugs, visit our website at www.wellmark.com or check with your pharmacist or physician.

However, exceptions may be made for certain prescriptions packaged in a dose exceeding the maximum quantity covered under this Blue Rx Preferred prescription drug plan. To determine if this exception applies to your prescription, call the toll-free Customer Service number on your ID card.

Refills

To qualify for refill benefits, all of the following requirements must be met:

- Sufficient time has elapsed since the last prescription was written. Sufficient time means that at least 75 percent of the medication has been taken according to the instructions given by the practitioner.
- The refill is not to replace medications that have been lost, damaged, stolen, or used inappropriately.
- The refill is for use by the person for whom the prescription is written (and not someone else).
- The refill does not exceed the amount authorized by your practitioner.
- The refill is not limited by state law.

You are allowed one early refill per medication per calendar year if you will be away from home for an extended period of time.

If traveling within the United States, the refill amount will be subject to any applicable quantity limits under this coverage. If traveling outside the United States, the refill amount will not exceed a 90-day supply.

To receive authorization for an early refill, ask your pharmacist to call us.

4. General Conditions of Coverage, Exclusions, and Limitations

The provisions in this section describe general conditions of coverage and important exclusions and limitations that apply generally to all types of services or supplies.

Conditions of Coverage

Medically Necessary
A key general condition in order for you to receive benefits is that the service, supply, device, or drug must be medically necessary. Even a service, supply, device, or drug listed as otherwise covered in *Details - Covered and Not Covered* may be excluded if it is not medically necessary in the circumstances. Unless otherwise required by law, Wellmark determines whether a service, supply, device, or drug is medically necessary, and that decision is final and conclusive. Even though a provider may recommend a service or supply, it may not be medically necessary.

A service, supply, device, or drug must meet all of the following standards:

- Medically appropriate and necessary for the symptoms, diagnosis, and direct treatment of your illness or injury.
- Consistent with professionally recognized standards of health care and provided at the correct time and setting.
- Not primarily for your or your provider's convenience.
- The most appropriate supply or level of service that can safely be provided.
- Enables you to make reasonable progress in treatment.

An alternative service, supply, device, or drug may meet the criteria of medical necessity for a specific condition. If alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, we reserve the right to approve the least costly alternative.

If you receive services that are not medically necessary, you are responsible for the cost if the services were received from:

- a nonparticipating provider; or
- a participating provider who informs you in writing before rendering services that Wellmark determined the services to be not medically necessary. If you do not receive this written notice, the participating provider is responsible for these amounts.

Member Eligibility
Another general condition of coverage is that the person who receives services must meet requirements for member eligibility. See *Coverage Eligibility and Effective Date*, page 49.

General Exclusions

Even if a service, supply, device, or drug is listed as otherwise covered in *Details - Covered and Not Covered,* it is not eligible for benefits if any of the following general exclusions apply.

Investigational or Experimental
You are not covered for a service, supply, device, or drug that is investigational or experimental. A treatment is considered investigational or experimental when it has progressed to limited human application but has not achieved recognition as being proven effective in clinical medicine.

To determine investigational or experimental status, we may refer to the technical criteria established by the Blue Cross and Blue Shield Association. These criteria include whether a service, supply, device, or drug is:

- Recognized as having received final governmental regulatory approval for a specific diagnosis;
- Scientifically recognized as being effective in improving health outcomes for a specific diagnosis; and
- At least as beneficial and no more expensive than any reasonable alternative for a specific diagnosis.

These criteria are considered by the Blue Cross and Blue Shield Association's Medical Advisory Panel in publishing a Reference Manual for consideration by all Blue Cross and Blue Shield member organizations. While we may use the criteria in this Reference Manual, the final decision remains at the discretion of our Medical Director, whose decision may include reference to, but is not controlled by, policies or decisions of other member organizations. Copies of the evaluation criteria and the reference manual information for a specific service, supply, device, or drug are available upon request.

Complications of a Noncovered Service
You are not covered for a complication resulting from a noncovered service, supply, device, or drug. However, this exclusion does not apply to the treatment of complications resulting from smallpox vaccinations when payment for such treatment is not available through workers' compensation or government-sponsored programs.

Nonmedical Services
You are not covered for telephone consultations, charges for missed appointments, charges for completion of any form, or charges for information.

Personal Convenience
You are not covered for personal convenience items that are useful in the absence of illness or injury (including, but not limited to, air conditioners, dehumidifiers, ramps, home remodeling, hot tubs, and swimming pools).

Provider Is Family Member
You are not covered for a service or supply received from a provider who is in your immediate family (which includes yourself, parent, child, or spouse or domestic partner).

Covered by Other Programs or Laws
You are not covered for a service, supply, device, or drug if:

- You are entitled to claim benefits from a governmental program (other than Medicaid).
- Someone else has the legal obligation to pay for services and without this group health plan, you would not be charged.
- You require services or supplies for an illness or injury sustained while on active military status.

Workers' Compensation
You are not covered for services or supplies that are compensated under workers' compensation laws, including services or supplies applied toward satisfaction of any deductible under your employer's workers' compensation coverage. You are also not covered for any services or supplies that could have been compensated under workers' compensation laws if you had complied with the legal requirements relating to notice of injury, timely filing of claims, and medical treatment authorization.

For treatment of complications resulting from smallpox vaccinations, see *Complications of a Noncovered Service* earlier in this section.

Benefit Limitations

Benefit limitations refer to amounts for which you are responsible under this group health plan. These amounts are not credited toward your out-of-pocket maximum. In addition to the exclusions and conditions described earlier, the following are examples of benefit limitations under this group health plan:

- A service or supply that is not covered under this group health plan is your responsibility.
- If a covered service or supply reaches a service or prescription maximum, it is no longer eligible for benefits. (A maximum may renew at the next benefit year.) See *Details – Covered and Not Covered,* page 13.
- If you receive total benefits in an amount that reaches a lifetime benefits maximum, you are no longer eligible for benefits under this group health plan. See *Lifetime Benefits Maximum*, page 5, and *At a Glance–Covered and Not Covered*, page 7.
- If you do not obtain precertification for medical services, benefits can be reduced or denied. You are responsible for these benefit reductions only if you are responsible (not your provider) for notification. See *Notification Requirements and Care Coordination*, page 37.
- If you do not obtain prior authorization for prescription drugs, benefits can be reduced or denied. See *Notification Requirements and Care Coordination*, page 37.
- The type of provider you choose can affect your benefits and what you pay. See *Choosing a Provider*, page 33, and *Factors Affecting What You Pay*, page 43. Examples of charges that depend on the type of provider include but are not limited to:
  - Any difference between the billed charge and our settlement amount is your responsibility if you receive services from a nonparticipating practitioner.

5. Choosing a Provider

Program 3 Plus

This medical benefits plan is called Program 3 Plus.

Although Program 3 Plus allows you to receive covered services from almost any provider who is eligible to provide the services, it is usually to your advantage to receive services from participating providers. Participating providers participate with a Blue Cross and/or Blue Shield Plan. You will usually pay less for services you receive from participating providers than for services you receive from nonparticipating providers.

Providers who do not participate with a Blue Cross and/or Blue Shield Plan are called nonparticipating providers.

See *What You Pay,* page 3 and *Factors Affecting What You Pay,* page 43.

To determine if a provider participates with this medical benefits plan, ask your provider, visit our website at www.wellmark.com, or www.bcbs.com, or call **800-810-BLUE**.

For types of providers that may be covered under this medical benefits plan, see *Hospitals and* Facilities, page 17 and *Physicians and Practitioners*, page 21.

Please note: Even though a facility may be participating, particular providers within the facility may not be participating providers. Examples include nonparticipating physicians on the staff of a participating hospital, home medical equipment suppliers, and other independent providers. Therefore, when you are referred by a participating provider to another provider, or when you are admitted into a facility, always ask if the providers contract with a Blue Cross and/or Blue Shield Plan.

Always carry your ID card and present it when you receive services. Information on it, especially the ID number, is required to process your claims correctly.

Pharmacies do not participate with Program 3 Plus, although some pharmacies may still file claims for you electronically.

Provider Comparison Chart	**Participating**	**Nonparticipating**
Accepts Blue Cross and/or Blue Shield payment arrangements.	Yes	No
Minimizes your payment obligations. See *What You Pay,* page 3.	Yes	No
Claims are filed for you.	Yes	No
Blue Cross and/or Blue Shield settles with these providers directly.	Yes	No
Notification requirements are handled for you.	No	No

Services Outside the Wellmark Service Area

Whenever possible, before receiving services outside the Wellmark service area, you should ask the provider if he or she participates with a Blue Cross and/or Blue Shield Plan in that state. To locate participating providers in any state, call **800-810-BLUE**, or visit www.bcbs.com.

Iowa and South Dakota comprise the Wellmark service area.

BlueCard Program. We participate with other Blue Cross and Blue Shield Plans in a national program called the BlueCard Program. This program ensures that members of any Blue Plan have access to the advantages of participating providers throughout the United States.

The BlueCard Program is one of the advantages of your coverage with Wellmark Blue Cross and Blue Shield of Iowa. It provides conveniences and benefits outside the Wellmark service area similar to those you would have within our service area when you obtain covered medical services from a participating provider. Always carry your ID card (or BlueCard) and present it to your provider when you receive care. Information on it, especially the ID number, is required to process your claims correctly.

When you receive covered services from BlueCard providers outside the Wellmark service area, all of the following statements are true:

- Claims are filed for you.
- These providers agree to accept payment arrangements or negotiated prices of the Blue Cross and/or Blue Shield Plan in their home state, which may result in savings.
- The settlement amount is sent directly to the providers.

When you receive covered services from BlueCard providers outside the Wellmark service area, you are responsible for notification requirements. See *Notification Requirements and Care Coordination*, page 37.

Care in a Foreign Country

For covered services you receive in a country other than the United States, payment level assumes the provider category is nonparticipating except for services received from providers that participate with BlueCard Worldwide.

Blue Rx Preferred

Choosing a Pharmacy

This prescription drug plan is called Blue Rx Preferred. Pharmacies that participate with the network used by Blue Rx Preferred are called participating pharmacies. Pharmacies that do not participate with the network are called nonparticipating pharmacies.

To determine if a pharmacy is participating, ask the pharmacist, consult the Blue Rx Preferred directory of participating pharmacies (as a separate document that's available, without charge), visit our website at www.wellmark.com, or call us.

Blue Rx Preferred allows you to purchase covered prescription drugs from almost any pharmacy you choose. However, you will usually pay more for prescription drugs when you purchase them from nonparticipating pharmacies. We recommend you:

- Fill your prescriptions at a participating pharmacy or through the mail order drug program. See *Mail Order Prescription Program* later in this section.
- Advise your physician that you are covered under Blue Rx Preferred.
- Always present your ID card when filling prescriptions. Your ID card enables participating pharmacists to access your benefits information.

Advantages of Visiting Participating Pharmacies

When you fill your prescription at participating pharmacies:

- You will usually pay less. If you use a nonparticipating pharmacy, you must pay the billed charge at the time of purchase, and the amount we reimburse you may be less than what you paid. You are responsible for this difference.
- Claims are filed for you. If you use a nonparticipating pharmacy, you are responsible for filing the claim.
- The participating pharmacist can check whether your prescription is subject to prior authorization or quantity limits.
- The participating pharmacist can access your benefit information, verify your eligibility, check whether the prescription is a benefit under the Blue Rx Preferred prescription drug plan, list the amount you are expected to pay, and suggest generic alternatives.

Always Present Your ID Card

If you do not have your ID card with you when you fill a prescription at a participating pharmacy, the pharmacist may not be able to access your benefit information. In this case:

- You must pay the full billed charge at the time you receive your prescription, and the amount we reimburse you may be less than what you paid. You are responsible for this difference.
- You must file your claim to be reimbursed. See *Claims*, page 59.

Mail Order Prescription Program

Registering for the Program

You must register as a Walgreens Mail Service User in order to fill your prescription(s) through the mail order drug program. You may register by:

- Completing a registration and prescription order form at our website, www.wellmark.com; or
- Calling Walgreens Mail Service at **866-611-5961**.

Initial Order

Orders may be placed by mail or faxed from your physician's office.

Mail your original prescription(s), payment, and the completed registration and prescription order form to:

Walgreens Mail Service
P.O. Box 29061
Phoenix, AZ 85038-9061

For orders placed by mail, you may pay by credit card, check, or money order. Do not send cash.

Or ask your physician to fax your prescription to Walgreens Mail Service at **866-212-5759**. Physician fax order forms are available at our website, www.wellmark.com or by calling the Customer Service number on your ID card. Faxed prescriptions are only valid when faxed from your physician's office.

If you place your order by fax, you must pay by credit card.

Prescription(s) are typically delivered within 10 to 14 days after the order is received.

Refill Orders

You may place refill orders online at www.wellmark.com, by calling **800-797-3345**, or by mailing a completed Walgreens refill request slip to:

Walgreens Mail Service
P.O. Box 29061
Phoenix, AZ 85038-9061

Each time you submit a prescription order through the mail order program, in addition to your prescription, you will also receive a reorder form and envelope and a refill request slip notifying you of when you can request a refill and the number of refills remaining (if any).

6. Notification Requirements and Care Coordination

Program 3 Plus

Many services require a notification to us or a review by us. If you do not follow notification requirements properly, you may have to pay for services yourself, so the information in this section is critical.

More than one of the notification requirements and care coordination programs described in this section may apply to a service. Any notification or care coordination decision is based on the medical benefits plan in effect at the time of your request. If your coverage changes for any reason, you may be required to repeat the notification process.

You or your authorized representative, if you have designated one, may appeal a denial or reduction of benefits resulting from these notification requirements and care coordination programs. See *Appeals*, page 67. Also see *Authorized Representative*, page 69.

Precertification

Purpose	Precertification helps determine whether a service or admission to a facility is medically necessary. This notification requirement is mandatory; however, it does not apply to maternity or emergency services.
Applies to	Acute Rehabilitation Facilities Home Health Services Home Infusion Therapy Hospice Services Nursing Facilities Facilities Outside Iowa or South Dakota
Person Responsible	Participating providers in the states of Iowa and South Dakota obtain precertification for you. However, you or someone acting on your behalf are responsible for notifying us if: ■ You are admitted to a facility outside Iowa or South Dakota; ■ You receive any of the services listed above from a nonparticipating provider.
Process	When you, instead of your provider, are responsible for precertification, call the phone number on your ID card before receiving services. Wellmark will respond to a precertification request within: ■ 72 hours in a medically urgent situation; ■ 15 days in a non-medically urgent situation.

Importance	If you choose to obtain any service subject to precertification even though we were unable to certify its medical necessity, you will be responsible for the charges. Even if a service is medically necessary and otherwise covered, without precertification, benefits will be reduced by 50% of the maximum allowable fee, after which we subtract your applicable payment obligations. The maximum reduction for services other than chemical dependency treatment will not exceed $500 per benefit year. The benefit reduction for chemical dependency services is not subject to a dollar limit. See *Maximum Allowable Fee*, page 44. You are subject to this benefit reduction only if you (instead of your provider) are responsible for notification. Reduced or denied benefits that result from failure to follow notification requirements are not credited toward your out-of-pocket maximum. See *What You Pay*, page 3.

Prior Approval

Purpose	Prior approval helps determine whether a proposed treatment plan is medically necessary and a benefit under your medical plan before you receive services. This notification is recommended.
Applies to	The most common services for which we recommend prior approval include, but are not limited to, the following list. For a complete list of services subject to prior approval, visit www.wellmark.com or call the Customer Service phone number on your ID card. Genetic Testing Home/Durable Medical Equipment Infertility Procedures including all forms of in vitro fertilization Weight Reduction Surgery Obstructive Sleep Apnea Treatment Reconstructive Surgery Speech Therapy Transplants
Person Responsible	Participating providers request prior approval for you. You are responsible for prior approval if you receive the care from a nonparticipating provider.
Process	When you, instead of your provider, are responsible for requesting prior approval, call the number on your ID card to obtain a prior approval form and ask the provider to help you complete the form. Wellmark will determine whether the requested service is medically necessary and eligible for benefits based on the written information submitted to us. We will respond to a prior approval request by mailing the decision to the most current address on record for both you and your provider within: ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation.

Importance	If your request is approved, the service is covered provided other contractual requirements, such as member eligibility and service maximums, are observed. If your request is denied, the service is not covered, and you will receive a notice with the reasons for denial. If you do not request prior approval for a service, it may not be covered. Approved services are eligible for benefits for a limited time. Approval is based on the medical benefits plan in effect and the information we had as of the approval date. If your coverage changes for any reason (for example, because of a new job or a new medical benefits plan), an approval may not be valid. If your coverage changes before the approved service is performed, a new approval is recommended. **Note:** An admission to a facility outside Iowa or South Dakota to receive a service for which prior approval is recommended is also subject to precertification. See *Precertification* earlier in this section.

Continued Stay Review

Purpose	Continued stay review helps determine whether ongoing care is medically necessary. This care coordination program occurs without any notification required from you.
Applies to	Inpatient Facility Admission Home Health Services Home Infusion Therapy Hospice Services
Person Responsible	Wellmark
Process	Wellmark may review your case to determine whether your current level of care is medically necessary.
Importance	Wellmark may require a change in the level or place of service in order to continue providing benefits. If we determine that your current level of care is no longer medically necessary, we will notify you, your attending physician, and the facility or agency at least 24 hours before your benefits for these services end.

Case Management

Purpose	Case management is a process of considering alternative treatments for members with severe illnesses or injuries that require costly, long-term care. Depending on the individual circumstances, a hospital may not be the most appropriate setting for treatment.

Applies to	Examples where case management might be appropriate include but are not limited to: Brain or Spinal Cord Injuries Cystic Fibrosis Degenerative Muscle Disorders Hemophilia Home Health Services Pregnancy (high risk) Transplants
Person Responsible	You, your physician, and the health care facility can work with Wellmark's case managers to identify and arrange alternative treatment plans to meet special needs. Wellmark may initiate a request for case management.
Process	Wellmark's case managers try to identify alternative settings or treatment plans, provided costs do not exceed those of an inpatient facility. A benefit program is tailored to the circumstances of the case. Even if a service is not covered or is subject to a specific limitation, Wellmark may waive exclusions or limitations with the agreement of its medical director. If your current level or setting of care is no longer medically necessary, you, your attending physician, and the facility or agency will be notified at least 24 hours before benefits end.
Importance	Case management provides an opportunity to receive alternative benefits to meet special needs. Wellmark may recommend a different treatment plan that preserves coverage.

Blue Rx Preferred

Prior Authorization of Drugs

Purpose	Prior authorization allows us to verify that a prescription drug is part of a specific treatment plan and is medically necessary. In some cases prior authorization may also allow a drug that is normally excluded to be covered if it is part of a specific treatment plan and medically necessary.
Applies to	Prior authorization is required for a number of particular drugs. Visit www.wellmark.com or check with your pharmacist or practitioner to determine whether prior authorization applies to a drug that has been prescribed for you.

Process	Ask your practitioner to call us with the necessary information. If your practitioner has not provided the prior authorization information, participating pharmacists usually ask for it, which may delay filling your prescription. To avoid delays, encourage your provider to complete the prior authorization process before you visit the pharmacy. Nonparticipating pharmacists will fill a prescription without prior authorization but you will be responsible for paying the charge. Wellmark will respond to a prior authorization request within: ■ 72 hours in a medically urgent situation. ■ 15 days in a non-medically urgent situation. Calls received after 4:00 p.m. are considered the next business day.
Importance	If you purchase a drug that requires prior authorization but do not request prior authorization, you are responsible for paying the entire billed charge.

7. Factors Affecting What You Pay

How much you pay for covered services is affected by many different factors discussed in this section.

Program 3 Plus

Benefit Year

A benefit year is the same as a calendar year and starts over each January 1. It continues even if you change benefits under the medical benefits plan sponsored by your employer or group sponsor and administered by Wellmark Blue Cross and Blue Shield of Iowa.

If you are an inpatient in a covered facility on the date your benefit year renews, your benefit calculations and payment obligations for facility services will also renew and will be based on the amounts in effect on the date you were admitted. However, your benefit calculations and payment obligations for practitioner services will be based on the amounts in effect on the day you receive services.

The benefit year is important for calculating:

- Deductible.
- Coinsurance.
- Out-of-pocket maximum.
- Service maximum.

How Coinsurance is Calculated

The amount on which coinsurance is calculated depends on the state where you receive a covered service and the contracting status of the provider.

Participating and Nonparticipating Providers

Coinsurance is calculated using the payment arrangement amount after the following applicable amounts are subtracted from it:

- Deductible.
- Certain copayments.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 29.

BlueCard Providers Outside the Wellmark Service Area

The coinsurance for covered services is calculated on the lower of:

- The billed charge for the covered service, or
- The payment arrangement or negotiated price that the local Blue Cross or Blue Shield Plan passes on to Wellmark after the following amounts (if applicable) are subtracted from it:
  - Deductible.
  - Certain copayments.
  - Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 29.

Often, the payment arrangement or negotiated price consists of a simple discount that reflects the actual price paid by the local Blue Plan. Sometimes, it is an estimated price that factors in expected settlements, withholds, and other contingent payment arrangements and non-claims transactions with the health care provider or a specific group of providers. The payment arrangement or negotiated price may also be billed charges reduced to reflect an average expected savings with the provider or group of providers. A price that reflects average savings may result in greater variation from the actual price paid than will an estimated price. The payment arrangement or negotiated price may also be adjusted in the future to correct for over-

or under-estimates of past prices; however, the amount you pay is considered a final price.

Occasionally, claims for services you receive from a provider that participates with a Blue Cross and/or Blue Shield Plan outside of Iowa or South Dakota may need to be processed by Wellmark instead of by the BlueCard Program. In that case, coinsurance is calculated using the billed charge for covered services after the following applicable amounts are subtracted from it:

- Deductible.
- Certain copayments.
- Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 29.

Statutes in a few states may require the local Blue Plan to use a basis for calculating your payment obligation for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. In such a case, Wellmark would calculate your payment obligation in accordance with the applicable state statute in effect at the time you received your care. For more information, see *BlueCard Program*, page 34.

Participating Providers

Wellmark and Blue Cross and/or Blue Shield Plans have contracting relationships with participating providers. When you receive services from participating providers:

- You are not responsible for any difference between the billed charge and the maximum allowable fee.
- These providers agree to accept Wellmark's payment arrangements, which may result in savings.
- Wellmark settles claims directly with these providers.

Nonparticipating Providers

Wellmark and Blue Cross and/or Blue Shield Plans do not have contracting relationships with nonparticipating providers. When you receive services from nonparticipating providers:

- You are responsible for any difference between the billed charge and the maximum allowable fee for a covered service when the maximum allowable fee is less than the practitioner's billed charge.
- Wellmark does not settle claims directly with these providers. You are responsible for ensuring that your provider is paid in full.
- Wellmark's settlement amount for nonparticipating hospitals, M.D.s, and D.O.s in Iowa are made payable to the provider, but the check is sent to you. You are responsible for forwarding the check to the provider (plus any billed balance you may owe).

Billed Charge and Maximum Allowable Fee

Billed Charge

The billed charge is the amount a provider bills for a service or supply, regardless of whether the services or supplies are covered under this medical benefits plan.

Maximum Allowable Fee

The maximum allowable fee is the amount, established by Wellmark, using various methodologies for covered services and supplies. Wellmark's settlement amount may be based on the lesser of the billed charge for a covered service or supply or the maximum allowable fee.

Payment Arrangements

Payment Arrangement Savings

Wellmark has contracting relationships with participating providers. We use different methods to determine payment arrangements, including negotiated fees.

These payment arrangements usually result in savings.

The savings from payment arrangements and other important amounts will appear on your Explanation of Benefits statement as follows:

- *Provider Savings*, which reflects the amount saved on a claim due to contracts with providers. For the majority of services, the savings amount reflects the actual amount saved on a claim. However, depending on many factors, the amount we pay a facility could be different than the covered charge. Regardless of the amount we pay a facility, your payment responsibility will always be based on the lesser of the covered charge or the maximum allowable fee.
- *Benefit Limitations*, which reflects amounts for which you are responsible. For general exclusions and examples of benefit limitations, see *General Conditions of Coverage, Exclusions, and Limitations*, page 29.
- *Our Settlement Amount*, which reflects our responsibility to a provider. For some providers, this amount may not necessarily equal the amount we actually pay the provider. We determine our settlement amount by subtracting the following applicable amounts from the billed charge:
  - Deductible.
  - Coinsurance.
  - Copayment.
  - Amounts representing any general exclusions and conditions. See *General Conditions of Coverage, Exclusions, and Limitations*, page 29.
  - Provider savings.

Payment Method for Services
Provider payment arrangements are calculated using industry methods, including but not limited to fee schedules, per diems, percentage of charge, per case, or negotiated fees. Some provider payment arrangements may include an amount payable to the provider based on the provider's performance. Performance-based amounts that are not distributed are not allocated to your specific group or to your specific claims and are not considered when determining any amounts you may owe. We reserve the right to change the methodology we use to calculate payment arrangements based on industry practice or business need. Participating providers agree to accept our payment arrangements as full settlement for providing covered services, except to the extent of any amounts you may owe.

Global Pricing Arrangement
An all-inclusive payment arrangement between a transplant center and Wellmark Blue Cross and Blue Shield of Iowa or the Blue Cross and Blue Shield Association which bundles the costs of an organ transplant into one charge for hospitalization, physician fees, and organ procurement.

Provider Savings
Wellmark's contracts with providers lowers some costs. These amounts are designated Provider Savings on your Explanation of Benefits statement following a claim.

Wellmark Drug List

Most prescription drugs are covered under Blue Rx Preferred, your prescription drug plan.

Often there is more than one medication available to treat the same medical condition. The Wellmark Drug List contains drugs physicians recognize as medically effective for a wide range of health conditions.

The Wellmark Drug List was developed with the assistance of physicians, pharmacists, and Wellmark's pharmacy benefits manager. It is not a required list of medications and physicians are not limited to prescribing only the drugs that appear on the list. Physicians may prescribe any medication, and that medication will be covered unless it is specifically excluded

under this medical benefits plan, or other limitations apply.

To determine if a drug is on the Wellmark Drug List, ask your physician, pharmacist, or visit our website, www.wellmark.com.

The Wellmark Drug List is subject to change.

Drug Company Rebates
Drug manufacturers offer rebates to pharmacy benefits managers. Wellmark receives a share of these rebates from its pharmacy benefits manager. Any rebates we receive will be retained by us and applied first to reduce the costs of administering the pharmacy program. The rebates will not be allocated to your specific group or to your specific claims and they will not be considered when determining your payment obligations.

Blue Rx Preferred

Benefit Year

A benefit year is the same as a calendar year. It begins on the day your coverage goes into effect and starts over each January 1.

The benefit year is important for calculating:

- Out-of-pocket maximum.

Wellmark Drug List

Often there is more than one medication available to treat the same medical condition. The Wellmark Drug List contains drugs physicians recognize as medically effective for a wide range of health conditions.

The Wellmark Drug List was developed with the assistance of physicians, pharmacists, and Wellmark's pharmacy benefits manager. It is not a required list of medications and physicians are not limited to prescribing only the drugs that appear on the list. Physicians may prescribe any medication, and that medication will be covered unless it is specifically excluded under this Blue Rx Preferred prescription drug plan, or other limitations apply.

To determine if a drug is on the Wellmark Drug List, ask your physician, pharmacist, or visit our website, www.wellmark.com.

The Wellmark Drug List is subject to change.

Tiers
The Wellmark Drug List also identifies which tier a drug is on:

Tier 1 Most generic drugs. Tier 1 drugs have the lowest payment obligation.

Tier 2 Selected brand name drugs and branded generic drugs. Many drugs appear on this tier because they have no generic equivalent. Tier 2 drugs have an intermediate payment obligation.

Tier 3 Other brand name drugs. Many drugs appear on this tier because they have reasonable alternatives on Tier 1 or Tier 2. Tier 3 drugs have the highest payment obligation.

Upon introduction of an FDA-approved "A"-rated generic equivalent, the generic drug's Tier 2 counterpart may be moved to Tier 3.

Generic and Brand Name Drugs

Generic Drug
Generic drug refers to an FDA-approved "A"-rated generic drug. This is a drug with active therapeutic ingredients chemically identical to its brand name drug counterpart.

Brand Name Drug
Brand name drug is a prescription drug patented by the original manufacturer. Usually, after the patent expires, other manufacturers may make FDA-approved generic copies.

Sometimes, a patent holder of a brand name drug grants a license to another manufacturer to produce the drug under a generic name, though it remains subject to patent protection and has a nearly identical price. In these cases, Wellmark's pharmacy benefits manager may treat the licensed product as a brand name drug, rather than generic, and will calculate your payment obligation accordingly.

Branded Generic Drug
Branded generic drug is a substitute prescription drug with the same active chemical ingredients as a brand name drug. This category of drug is treated as a brand name drug throughout the industry for one or both of the following reasons:

- It is not made under the original patent, but the manufacturer traditionally makes brand name drugs instead of generics.
- The drug's price is not significantly lower than that of the brand name drug.

What You Pay
For Tier 2 or Tier 3 drugs, in addition to the copayment, you may also be responsible for any cost difference between the billed charge for the Tier 2 or Tier 3 drug and the billed charge for the Tier 1 drug. See the following chart.

Situation	Applicable Copayment	Cost Difference Owed
Your prescription is for a generic and you purchase a generic.	Tier 1 copayment	No
Your prescription is for a drug that has an FDA-approved "A"-rated generic equivalent and your physician has not specified that you must take the brand name drug, but you choose to purchase the brand name drug.	Tier 2 or 3 copayment	Yes
Your prescription is for a brand name drug and your practitioner has specified that a generic is not allowed, and the prescription must be dispensed as written.	Tier 2 or 3 copayment	Yes
Your prescription is for a narrow therapeutic index brand name drug. This means that a very small change in the dosage level could cause toxic results.	Tier 2 or 3 copayment	No
Your prescription is for a brand name drug and the FDA does not rate an available generic substitute for the brand name drug as "A"-equivalent.	Tier 2 or 3 copayment	No

Quantity Limitations

The drug quantity you purchase may affect the total number of copayments that apply per prescription.

Most prescription drugs are limited to a maximum quantity you may receive in a single prescription. However, exceptions may be made for certain prescriptions packaged in a dose exceeding the maximum quantity covered under this Blue Rx Preferred prescription drug plan. To determine if this exception applies to your prescription, call the toll-free Customer Service number on your ID card.

In addition, coverage for certain drugs are limited by month, benefit year, or lifetime. For a list of limited drugs, check with your

pharmacist or physician or visit our website, www.wellmark.com.

Billed Charge and Maximum Allowable Fee

Billed Charge
The retail price charged by a pharmacy for a covered prescription drug.

Maximum Allowable Fee
The amount, established by Wellmark using various methodologies and data (such as the average wholesale price), payable for covered drugs.

The maximum allowable fee may be less than the billed charge of the drug.

Participating vs. Nonparticipating Pharmacies

If you do not purchase a covered prescription drug at a participating pharmacy, you are responsible for the billed charge of the drug at the time you fill your prescription.

Once you submit a claim, you will be reimbursed up to the maximum allowable fee of the drug less your payment obligation. The maximum allowable fee may be less than the amount you paid. In other words, in addition to your payment obligation, you are also responsible for any difference in cost between what the pharmacy charges you for the drug and our reimbursement amount.

Your payment obligation for the purchase of a covered prescription drug at a participating pharmacy is the lesser of the copayment or the billed charge for the drug.

Savings and Rebates

Payment Arrangements
The benefits manager of this prescription drug program has established payment arrangements with participating pharmacies that may result in savings.

Drug Company Rebates
Drug manufacturers offer rebates to pharmacy benefits managers. Wellmark receives a share of these rebates from its pharmacy benefits manager. Any rebates we receive will be retained by us and applied first to reduce the costs of administering the pharmacy program. The rebates will not be allocated to your specific group or to your specific claims and they will not be considered when determining your payment obligations.

8. Coverage Eligibility and Effective Date

Eligible Members

You are eligible for coverage if you meet your employer's or group sponsor's eligibility requirements. Also eligible for coverage is an eligible member's spouse or domestic partner.

A dependent child is eligible under the plan member's coverage if the child has any of the following relationships to the plan member or an enrolled spouse or domestic partner:

- A natural child.
- Legally adopted or placed for adoption (that is, you assume a legal obligation to provide full or partial support and intend to adopt the child).
- A child for whom you have legal guardianship.
- A stepchild.
- A foster child.
- A natural child a court orders to be covered.

A dependent child who has been placed in your home for the purpose of adoption or whom you have adopted is eligible for coverage on the date of placement for adoption or the date of actual adoption, whichever occurs first.

In addition, a dependent child must be unmarried and must be one of the following:

- Under age 19.
- A full-time student enrolled in an accredited educational institution. Full-time student status continues during regularly scheduled school vacations and during extended absences for up to four months due to a physical or mental disability.
- Totally and permanently disabled, physically or mentally. The disability must have existed before the child turned age 19, or while the child was a full-time student. In addition, the child must have had creditable coverage without a break of 63 days or more since turning age 19 or since becoming a full-time student.

Please note: In addition to the preceding requirements, eligibility is affected by coverage enrollment events and coverage termination events. See *Coverage Change Events*, page 55.

Enrollment Requirements

Permanent or probationary employees who work 20 or more hours per week are eligible to apply:

- within 30 calendar days of the date of hire; or
- at the first annual change period following date of hire.

Employees and dependents not enrolled during the period will be considered late enrollees, subject to an 18-month preexisting condition exclusion period—unless there is a qualifying event. See *Coverage Change Events*, page 55. Also see *Preexisting Condition Exclusion Period*, later in this section.

Promise Program

Promise Program employees, as established by Executive Order Number 27, may enroll in single or family coverage within 30 calendar days of expiration of their Medicaid benefits.

Program Selection/Program Movement

Rules on program selection and program movement are detailed in your *Employer's Procedures Manual* and *Collective Bargaining Agreements*.

When Coverage Begins

Coverage begins on the member's effective date, subject to any exclusion period described below.

Your coverage under this group health plan begins on your effective date, which is the first of the month following 30 days of active employment. **Please note:** The month of February is considered a 30-day period.

Any employee or former employee defined as eligible by the State of Iowa, whether actively at work or not, is accepted by the group health plan during an approved enrollment and change period.

This benefit booklet supersedes any other contractual language regarding the member's effective date, benefits available, eligibility, or payment for inpatient hospital, nursing facility, practitioner, or other inpatient charges for State of Iowa group members.

Services received before the effective date of coverage are not eligible for benefits.

Preexisting Condition Exclusion Period

You may be required to wait a specified time from your enrollment date before benefits are available for any medical services you receive for a preexisting condition. See *Duration of Exclusion Period* later in this section.

Preexisting Condition

A preexisting condition is an illness, injury, medical, surgical, or other condition for which medical advice, diagnosis, or treatment was recommended or received within the six months ending on your enrollment date. Pregnancy is not considered a preexisting condition.

When Exclusion Period Applies

A preexisting condition exclusion period applies if the member has a preexisting condition and:

- The member enrolls as a late enrollee. A late enrollee is a member who declines coverage when initially eligible to enroll and then later enrolls for coverage. However, a member is not a late enrollee if a qualifying enrollment event allows enrollment as a special enrollee, even if the enrollment event coincides with a late enrollment opportunity. See *Coverage Change Events*, page 55.
- The plan member is a new employee and applies for coverage when initially eligible to enroll.
- The member enrolls as a special enrollee under a qualifying enrollment event when initially eligible. See *Coverage Change Events*, page 55.

When a preexisting condition exclusion period applies, it begins on the enrollment date.

New Hire: If the plan member and his or her family members apply for coverage when first eligible, the enrollment date is the plan member's hire date.

Special Enrollee: If a member applies when he or she is first eligible as a result of a special enrollment event, the enrollment date is the date the plan member signed the application for coverage. See *Coverage Change Events*, page 55.

Late Enrollee: If a member is a late enrollee, the enrollment date is the date the member signed the application for coverage.

Duration of Exclusion Period

The preexisting condition exclusion period is:

- For a new employee or special enrollee who applies for coverage when initially eligible, 11 consecutive months, minus any period of prior creditable coverage.

- For a late enrollee, 18 consecutive months, minus any period of prior creditable coverage.

Prior Creditable Coverage

Prior creditable coverage reduces the preexisting condition exclusion period by the amount of time you had the prior coverage provided there was no break in coverage of 63 days or more. For instance, if you were covered by another medical benefits plan (without a break of 63 days or more) for the three-month period before your enrollment date under this medical benefits plan, and if this plan includes a 11-month preexisting condition exclusion period, your preexisting condition exclusion period would be reduced to eight months.

If an eligible dependent has more prior creditable coverage than the plan member, the dependent's preexisting condition exclusion period is reduced by his or her own period of prior creditable coverage.

If you have a newborn child or adopt a child prior to being covered under this medical benefits plan, the preexisting condition exclusion period will not apply to the child if he or she had prior creditable coverage at birth or on the date of placement for adoption (without a break in coverage of 63 days or more).

If you have a newborn child or adopt a child while you are covered under this medical benefits plan, the preexisting condition exclusion period will not apply to the child if you add him or her to your coverage within 60 days of birth, adoption, or placement in your home for adoption.

Creditable coverage means any of the following categories of coverage, during which there was no break in coverage of more than 63 days:

- Group health plan (including government and church plans).
- Health insurance coverage (including group, individual, and short-term limited duration coverage).
- Medicare (Part A or B of Title XVIII of the Social Security Act).
- Medicaid (Title XIX of the Social Security Act).
- Medical care for members and certain former members of the uniformed services, and for their dependents (Chapter 55 of Title 10, United States Code).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- Federal Employee Health Benefit Plan (a health plan offered under Chapter 89 of Title 5, United States Code).
- A State Children's Health Insurance Program (S-CHIP).
- A public health plan as defined in federal regulations (including health coverage provided under a plan established or maintained by a foreign country or political subdivision).
- A health benefits plan under Section 5(e) of the Peace Corps Act.
- An organized delivery system licensed by the director of public health.

You have the right to request certification of creditable coverage from the carrier or administrator of your prior coverage. Other types of coverage besides a group health plan may qualify as prior creditable coverage.

Qualified Medical Child Support Order

If you have a dependent child and you or your spouse's employer or group sponsor receives a Medical Child Support Order recognizing the child's right to enroll in this group health plan or in your spouse's benefits plan, the employer or group sponsor will promptly notify you or your spouse and the dependent that the order has been received. The employer or group sponsor also will inform you or your spouse and the dependent of its procedures for determining whether the order is a

Qualified Medical Child Support Order (QMCSO). Participants and beneficiaries can obtain, without charge, a copy of such procedures from the plan administrator.

A QMCSO specifies information such as:

- Your name and last known mailing address.
- The name and mailing address of the dependent specified in the court order.
- A reasonable description of the type of coverage to be provided to the dependent or the manner in which the type of coverage will be determined.
- The period to which the order applies.

A Qualified Medical Child Support Order can not require that a benefits plan provide any type or form of benefit or option not otherwise provided under the plan, except as necessary to meet requirements of Iowa Code Chapter 252E (2001) or Social Security Act Section 1908 with respect to group health plans.

The order and the notice given by the employer or group sponsor will provide additional information, including actions that you and the appropriate insurer must take to determine the dependent's eligibility and procedures for enrollment in the benefits plan, which must be done within specified time limits.

If eligible, the dependent will have the same coverage as you or your spouse do and will be allowed to enroll immediately. You or your spouse's employer or group sponsor will withhold any applicable share of the dependent's health care premiums from your compensation and forward this amount to us.

If you are subject to a waiting period that expires more than 90 days after the insurer receives the QMCSO, your employer or group sponsor must notify us when you become eligible for enrollment. Enrollment of the dependent will commence after you have satisfied the waiting period.

The dependent may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks, and other materials.

Your employer or group sponsor may not revoke enrollment or eliminate coverage for a dependent unless the employer or group sponsor receives satisfactory written evidence that:

- The court or administrative order requiring coverage in a group health plan is no longer in effect;
- The dependent's eligibility for or enrollment in a comparable benefits plan that takes effect on or before the date the dependent's enrollment in this group health plan terminates; or
- The employer eliminates dependent health coverage for all employees.

The employer or group sponsor is not required to maintain the dependent's coverage if:

- You or your spouse no longer pay premiums because the employer or group sponsor no longer owes compensation; or
- You or your spouse have terminated employment with the employer and have not elected to continue coverage.

Family and Medical Leave Act of 1993

The Family and Medical Leave Act of 1993, requires a public employer to allow an employee with 12 months or more of service and who has worked for 1,250 hours over the previous 12 months a total of 12 weeks of leave per fiscal year for the birth of a child, placement of a child with the employee for adoption or foster care, care for the spouse, child or parent of the employee if the individual has a serious health condition or because of a serious health condition, the employee is unable to perform any one of the essential functions of the employee's regular position.

Any employee taking a leave under the act shall be entitled to continue the employee's benefits during the duration of the leave. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. **Please note:** The employee is still responsible for paying their share of the premium if applicable. If the employee for any reason fails to return from the leave, the employer may recover from the employee that premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the reoccurrence of the serious health condition or circumstances beyond the control of the employee.

Leave taken under the Act does not constitute a qualifying event so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of 12 weeks of Family and Medical Leave and terminates employment with employer, the COBRA qualifying event occurs at that time.

If you have any questions regarding your eligibility or obligations under the Family Medical Leave Act, contact your employer or group sponsor.

9. Coverage Changes and Termination

Certain events may require or allow you to add or remove persons who are covered by this group health plan.

Coverage Change Events

Coverage Enrollment Events: The following events allow you as well as an affected spouse, domestic partner, or eligible child to enroll for coverage. If your employer or group sponsor offers more than one group health plan and you are already enrolled in one of the group health plans, the event also allows you to move from one plan option to another.

- Birth, adoption, or placement for adoption by an approved agency.
- Death.
- Divorce, annulment, or legal separation.
- Marriage.
- Exhaustion of COBRA coverage.
- Member, spouse, or dependent loses eligibility for creditable coverage or his or her employer or group sponsor ceases contribution to creditable coverage.
- Spouse loses coverage through his or her employer.

The following events allow you to add the person affected by the event:

- Attaining age 65.
- Becoming eligible for Medicare.
- Dependent child resumes status as a full-time student.
- Addition of a natural child by court order. See *Qualified Medical Child Support Order*, page 51.
- Appointment as a child's legal guardian.
- Placement of a foster child in your home by an approved agency.

Coverage Removal Events: The following events require you to remove the affected family member from your coverage:

- Active military service.
- Completion of a dependent's full-time schooling.
- Death.
- Dependent child who is not a full-time student or permanently disabled reaches age 19.
- Divorce, annulment, or legal separation.
- Marriage of a dependent child.
- Medicare eligibility. If you become eligible for Medicare, you must notify your employer or group sponsor immediately. If you are eligible for this group health plan other than as a current employee or a current employee's spouse, your Medicare eligibility may terminate this coverage.

You may change from family to single coverage at any time during the year. However, you are only able to change to family coverage as a late or special enrollee or with a qualifying event as described earlier under *Coverage Enrollment Events*.

Requirement to Notify Group Sponsor

You must notify your employer or group sponsor of an event that changes the coverage status of members.

Birth of a Child. A newborn will be added to the existing family health contract when information becomes available from any valid source that the birth has occurred (e.g., hospital or professional claims submission or an enrollment form). The effective date of enrollment will be the date of birth.

If a single contract is in effect at the time of the birth of a biological child, the employee must submit an application form to change to a family contract within 60 days of the date of the birth. The effective date of the family contract will be the first day of the month in which the biological child was born. Appropriate employee deductions for

payment of the family contract must be paid retroactively to reflect the change to a family contract.

If the single contractholder does not submit the application for family coverage within 60 days of the birth of the biological child, the child may be subject to an 18-month preexisting condition exclusion period for late enrollees and benefit payments will not be made retroactive to the date of birth. See *Preexisting Condition Exclusion Period*, page 50.

Adoption, Legal Custody, or Legal Guardianship. The following provisions apply for adoptions or obtaining legal custody or legal guardianship:

If a newborn child is adopted within 30 days of birth or has been placed in your home for the purposes of adoption within 30 days of birth, the effective date of coverage can be:

- the first of the month, in which the child was born; or
- the first of the month following the child's birth.

If you adopt a child or a child is placed in your home for the purposes of adoption more than 30 days after the child's date of birth, the effective date of coverage will be the first of the month in which the adoption or placement for adoption occurs. If you obtain legal custody or legal guardianship of a child more than 30 days after the child's date of birth, the effective date of coverage will also be the first of the month in which the legal action occurs.

Your application for coverage must be signed within 60 days of the event to add the new child to the existing family contract or allow a single contract to be changed to a family contract.

Legal documentation must accompany the application to add the new child indicating:

- employee name and social security number;
- date of birth of the child; and
- date awarded physical custody.

If custody is lost, it is the employee's responsibility to immediately notify their personnel assistant.

All Other Events. For all other events, you must notify your employer or group sponsor within 31 days of the event.

If you do not provide timely notification of an event that requires you to remove an affected family member, your coverage may be terminated.

If you do not provide timely notification of a coverage enrollment event, the person affected by a coverage enrollment event is subject to the 18-month preexisting condition exclusion period for late enrollees. See *Preexisting Condition Exclusion Period*, page 50.

Coverage Termination

The following events terminate your coverage eligibility.

- You become unemployed when your eligibility is based on employment.
- You become ineligible under your employer's or group sponsor's eligibility requirements for reasons other than unemployment.
- Your employer or group sponsor discontinues or replaces this group health plan.
- We terminate coverage of all similar group health plans by written notice to your employer or group sponsor 90 days prior to termination.

Also see *Fraud, Misrepresentation, Concealment of Material Facts, or Nonpayment* later in this section.

When you become unemployed and your eligibility is based on employment, your coverage will end at the end of the month your employment ends. When your coverage terminates for all other reasons, check with your employer or group sponsor or call the customer service number on your ID card to verify the coverage termination date.

If you are an inpatient of a hospital or a resident of a nursing facility on the date your coverage eligibility terminates, benefits for inpatient services are limited to the least amount of the following:

- The period of your remaining days of coverage under this medical benefits plan.
- The period ending on the date you are discharged from the facility.
- A period not more than 60 days from the date of termination.

Fraud, Misrepresentation, Concealment of Material Facts, or Nonpayment

Your coverage will terminate immediately if:

- You use this group health plan fraudulently or fraudulently misrepresent or conceal a material fact in your application; or
- Your employer or group sponsor commits fraud or intentionally misrepresents a material fact under the terms of this group health plan.
- You or your employer or group sponsor fails to make required payments to us when due, or you fail to pay any applicable amounts you owe.

If your coverage is terminated for fraud, misrepresentation, or the concealment of a material fact, then:

- We may declare this group health plan void.
- Premiums will be retroactively adjusted as if a misrepresented or concealed material fact had been accurately disclosed in your application.
- We will recover any claim payments made, minus any premiums paid.
- We will retain legal rights, including the right to bring a civil action.

Certificate of Creditable Coverage

Wellmark will provide certification of your coverage under this medical benefits plan if:

- This coverage terminates.
- You become eligible for COBRA coverage.
- You exhaust your COBRA coverage.
- You request certification of your coverage within 24 months after this coverage terminates. See *Notice*, page 73.

Coverage Continuation

When your coverage ends, you may be eligible to continue coverage under this group health plan or to convert to another Wellmark health benefits plan pursuant to certain state and federal laws.

COBRA Continuation

The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) applies to most non-governmental employers with 20 or more employees. Generally, COBRA entitles you and eligible dependents to continue coverage if it is lost due to a qualifying event, such as employment termination, divorce, or loss of dependent status. You and your eligible dependents will be required to pay for continuation coverage. Other federal or state laws similar to COBRA may apply if COBRA does not. Your employer or group sponsor is required to provide you with additional information on continuation coverage if a qualifying event occurs.

Continuation for Public Group

Iowa Code Sections 509A.7 and 509A.13 may apply if you are an employee of the State. Iowa Code Section 509A.13A may apply to the surviving spouse of a retired State employee. These laws may entitle you to continue participation in this medical benefits plan when you retire. You are responsible for paying any premiums to your employer.

10. Claims

Once you receive medical services or purchase prescription drugs we must receive a claim to determine the amount of your benefits. The claim lets us know the services or prescription drugs you received, when you received them, and from which provider.

When to File a Claim

You need to file a claim if you:

- Use a provider who does not file claims for you. Participating providers file claims for you.
- Purchase prescription drugs from a nonparticipating pharmacy.
- Purchase prescription drugs from a participating pharmacy but do not present your ID card.
- Pay in full for a drug that you believe should have been covered.

Wellmark must receive claims within 365 days after the end of the calendar year in which you receive services or purchase prescription drugs.

How to File a Claim

All claims must be submitted in writing.

1. Get a Claim Form

Forms are available at www.wellmark.com or by calling the Customer Service number on your ID card or from your personnel department.

2. Fill Out the Claim Form

Follow the same claim filing procedure regardless of where you received services. Directions are printed on the back of the claim form. Complete all sections of the claim form. For more efficient processing, all claims (including those completed out-of-country) should be written in English.

If you need assistance completing the claim form, call the Customer Service number on your ID card.

Medical Claim Form. Follow these steps to complete a medical claim form:

- Use a separate claim form for each covered family member and each provider.
- Attach a copy of an itemized statement prepared by your provider. We cannot accept statements you prepare, cash register receipts, receipt of payment notices, or balance due notices. In order for a claim request to qualify for processing, the itemized statement must be on the provider's stationery, and include at least the following:
  - Identification of provider: full name, address, tax or license ID numbers, and provider numbers.
  - Patient information: first and last name, date of birth, gender, relationship to plan member, and daytime phone number.
  - Date(s) of service.
  - Charge for each service.
  - Place of service (office, hospital, etc).
  - For injury or illness: date and diagnosis.
  - For inpatient claims: admission date, patient status, attending physician ID.
  - Days or units of service.
  - Revenue, diagnosis, and procedure codes.
  - Description of each service.

Prescription Drugs Covered Under Your Medical Benefits Plan Claim Form. For prescription drugs covered under your medical benefits plan (not covered under your Blue Rx Preferred prescription drug plan), use a separate prescription drug claim form and include the following information:

- Pharmacy name and address.

- Patient information: first and last name, date of birth, gender, and relationship to plan member.
- Date(s) of service.
- Description and quantity of drug.
- Original pharmacy receipt or cash receipt with the pharmacist's signature on it.

Blue Rx Preferred Prescription Drug Claim Form. For prescription drugs covered under your Blue Rx Preferred prescription drug plan, complete the following steps:

- Use a separate claim form for each covered family member and each pharmacy.
- Complete all sections of the claim form. Include your daytime telephone number.
- Submit up to three prescriptions for the same family member and the same pharmacy on a single claim form. Use additional claim forms for claims that exceed three prescriptions or if the prescriptions are for more than one family member or pharmacy.
- Attach receipts to the back of the claim form in the space provided.

3. Sign the Claim Form

4. Submit the Claim
We recommend you retain a copy for your records. The original form you send or any attachments sent with the form cannot be returned to you.

Medical Claims and Claims for Drugs Covered Under Your Medical Benefits Plan. Send the claim to:

Wellmark Blue Cross and Blue Shield of Iowa
636 Grand Avenue, Station 39
Des Moines, IA 50309-2565

Medical Claims for services received outside the United States. Send the claim to:

BlueCard Worldwide Service Center
P.O. Box 90320
Richmond, VA 23230-9320

Blue Rx Preferred Prescription Drug Claims. Send the claim to:

Catalyst Rx
Claims Department
P.O. Box 1069
Rockville, MD 20849-1069

We may require additional information from you or your provider before a claim can be considered complete and ready for processing.

Notification of Decision

We will send an Explanation of Health Care Benefits (EOB) following your claim. The EOB is a statement outlining how we applied benefits to a submitted claim. It details amounts billed, charged, our settlement amount, and amounts you still owe.

In case of an adverse decision, the notice will be sent within 30 days of receipt of the claim. We may extend this time by up to 15 days if the claim determination is delayed for reasons beyond our control. If we do not send an explanation of benefits statement or a notice of extension within the 30-day period, you have the right to begin an appeal. We will notify you of the circumstances requiring an extension and the date by which we expect to render a decision.

If an extension is necessary because we require additional information from you, the notice will describe the specific information needed. You have 45 days from receipt of the notice to provide the information. Without complete information, your claim will be denied.

If you have other insurance coverage, our processing of your claim may utilize

coordination of benefits guidelines. See *Coordination of Benefits*, page 63.

Once we settle your claim, whether the settlement amount is sent to you or to your provider, our obligation to pay benefits for the claim is discharged. In the case of nonparticipating hospitals, M.D.s, and D.O.s located in Iowa, the settlement amount we send to you will be made payable to the provider. You are responsible for forwarding the check to your provider, plus any difference between the billed charge and our settlement amount.

11. Coordination of Benefits

Coordination of benefits applies when you have more than one insurance policy or group health plan that provides the same or similar benefits as this plan. Benefits payable under this plan, when combined with those paid under your other coverage, will not be more than 100 percent of either our payment arrangement amount or the other plan's payment arrangement amount.

The method we use to calculate the payment arrangement amount may be different from your other carrier's method.

Other Coverage

When you receive services, you must inform us that you have other coverage, and inform your health care provider about your other coverage. Other coverage includes any of the following:

- Group and nongroup insurance contracts and subscriber contracts.
- Uninsured arrangements of group or group-type coverage.
- Group and nongroup coverage through closed panel plans.
- Group-type contracts.
- The medical care components of long-term contracts, such as skilled nursing care.
- Medicare or other governmental benefits (not including Medicaid).
- The medical benefits coverage of your auto insurance (whether issued on a fault or no-fault basis).

You must cooperate with Wellmark and provide requested information about other coverage. Failure to provide information can result in a denied claim.

Your participating provider will forward your coverage information to us. If you have a nonparticipating provider, you are responsible for informing us about your other coverage.

Claim Filing

If you know that your other coverage has primary responsibility for payment, after you receive services or obtain a covered prescription drug, a claim should be submitted to your other insurance carrier first. If that claim is processed with an unpaid balance for benefits eligible under this group health plan, you or your provider should submit a claim to us and attach the other carrier's explanation of benefit payment. We may contact your provider or the other carrier for further information.

Rules of Coordination

We follow certain rules to determine which group health plan pays first when other coverage provides the same or similar benefits as this group health plan. Here are some of those rules:

- The coverage without coordination of benefits pays first when one plan has coordination of benefits and one does not, unless the provisions of both plans state that the complying plan is primary.
- The medical coverage of your auto insurance pays before this plan if the auto insurance does not have a coordination of benefits provision that specifies it is secondary or excess to a health benefits plan.
- The coverage that you have as an employee, plan member, subscriber, policyholder or retiree pays before coverage that you have as a spouse or dependent. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed, so that the plan covering the person as the employee, plan member,

subscriber, policyholder or retiree is the secondary plan and the other plan is the primary plan.

- The coverage that you have as the result of active employment (not laid off or retired) pays before coverage that you have as a laid-off or retired employee. The same would be true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the person as an employee, plan member, subscriber, policyholder or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule and, as a result, the plans do not agree on the order of benefits, this rule is ignored.
- The coverage with the earliest continuous effective date pays first if none of the rules above apply.
- Notwithstanding the preceding rules, when you use your Blue Rx Preferred ID card, the benefits of your Blue Rx Preferred prescription drug plan are primary for prescription drugs purchased at a pharmacy.

Dependent Children

To coordinate benefits for a dependent child, the following rules apply (unless there is a court decree stating otherwise):

- If the child is covered by both parents who are not married (and not separated) or who are living together, whether or not they have been married, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
- For a child covered by separated or divorced parents or parents who are not living together, whether or not they have been married:
  - If a court decree states that one of the parents is responsible for the child's health care expenses or coverage and the plan of that parent has actual knowledge of those terms, then that parent's coverage pays first. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's coverage pays first. This item does not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.
  - If a court decree states that both parents are responsible for the child's health care expense or health care coverage or if a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or coverage of the dependent child, then the coverage of the parent whose birthday occurs first in a calendar year pays first. If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
  - If a court decree does not specify which parent has financial or insurance responsibility, then the coverage of the parent with custody pays first. The payment order for the child is as follows: custodial parent, spouse of custodial parent, other parent, spouse of other parent.

If none of these rules apply to your situation, we will use the Iowa Insurance Division's Coordination of Benefits

guidelines to determine our settlement amount.

In addition, this plan will not pay more than it would have paid had it been the primary plan.

Coordination with Medicare

For medical claims only, Medicare is by law the secondary coverage to group health plans in a variety of situations.

However, if you are eligible for Medicare either as a retiree or a spouse of a retiree or because of you or your spouse's disability status, your benefits under this medical benefits plan will be coordinated with benefits available under Medicare Part B, even if you or your spouse are not enrolled in Medicare Part B. Therefore, any member enrolled in Medicare Part A should also consider enrolling in Medicare Part B.

The following provisions apply only if you have both Medicare and employer group health coverage under this medical benefits plan and your employer has the required minimum number of employees.

Working Aged
Medicare is the secondary payer if the beneficiary is:

- Age 65 or older; and
- A current employee or spouse of a current employee covered by an employer group health plan.

Working Disabled
Medicare is the secondary payer if the beneficiary is:

- Under age 65;
- A recipient of Medicare disability benefits; and
- A current employee or a spouse or dependent of a current employee, covered by an employer group health plan.

End-Stage Renal Disease (ESRD)
Under ESRD requirements, Medicare is the secondary payer during the first 30 months of Medicare coverage if both of the following are true:

- The beneficiary has Medicare coverage as an ESRD patient; and
- The beneficiary is covered by an employer group health plan.

If the beneficiary is already covered by Medicare due to age or disability and the beneficiary becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payer during the first 30 months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary-payer requirements) at the time the beneficiary becomes covered for ESRD, the group health plan remains secondary to Medicare.

This is only a general summary of the laws, which may change from time to time. For more information, contact your employer or the Social Security Administration.

12. Appeals

Right of Appeal

You have the right to one full and fair review in case of a denied or reduced claim, or an adverse decision concerning a pre-service notification requirement. An adverse decision is one that denies or reduces benefits. Pre-service notification requirements are:

- Continued stay in a facility.
- A precertification request.
- A prior approval request.
- A prior authorization request for prescription drugs.

How to Appeal

You or your authorized representative, if you have designated one, may appeal a reduced or denied benefit by calling the Customer Service number on your ID card or by writing to Wellmark. See *Authorized Representative*, page 69.

Medically Urgent Appeal
For appeals involving a medically urgent situation, you may request an expedited appeal, either orally or in writing.

Non-Medically Urgent Appeal
For appeals that are not medically urgent, you must make your request for a review, in writing, within 180 days from the date you are notified of our adverse decision.

What to Include in Your Appeal
You must submit all relevant information with your initial appeal, including the reason for your appeal. This includes written comments, documents, or other information in support of your appeal. You must also submit:

- Date of your request.
- Your name (please type or print), address, and if applicable, the name and address of your authorized representative.
- Member identification number.
- Claim number from your Explanation of Benefits, if applicable.
- Date of service in question.

For a prescription drug appeal, you also must submit:

- Name and phone number of the pharmacy.
- Name and phone number of the practitioner who wrote the prescription.
- A copy of the prescription.
- A brief description of your medical reason for needing the prescription.

If you have difficulty obtaining this information, ask your provider or pharmacist to assist you.

Where to Send Appeal

Wellmark Blue Cross and Blue Shield of Iowa
Appeals
636 Grand Avenue, Station 52
Des Moines, IA 50309-2565

Review of Appeal

Your request for an appeal will be reviewed only once. The review will take into account all information regarding the adverse decision whether or not the information was presented or available at the initial determination. Upon request, and free of charge, you will be provided reasonable access to and copies of all relevant records used in making the initial decision.

The review will not be conducted by the original decision makers or any of their subordinates. The review will be conducted without regard to the original decision. If a decision requires medical judgment, we will consult an appropriate medical expert who was not previously involved in the original decision. If we deny your appeal, in whole or

in part, you may request, in writing, the identity of the medical expert we consulted.

Decision on Appeal

The decision on appeal is final. Once a decision on appeal is reached, your right to appeal is exhausted.

Medically Urgent Appeal
For a medically urgent appeal, you will be notified (by telephone, email, fax or another prompt method) of our decision as soon as possible, but no later than 72 hours after your expedited appeal is received. Written notification will follow within three days of the initial notice.

Non-Medically Urgent Appeal
An appeal of a denied or reduced claim will be decided within 60 days. An appeal of an adverse decision concerning a pre-service notification requirement will be decided within 30 days.

Legal Action

You shall not start legal action against us until you have exhausted the appeal procedure described in this section.

External Review Process

If you have exhausted our appeal process regarding a denial of benefits based on medical necessity, you or your provider, if you have authorized your provider to act on your behalf, may request an external review of our decision through the Iowa Commissioner of Insurance.

If you authorize your provider to act on your behalf, this authorization must be in writing, signed by you, and include all the information required in our Authorized Representative Form. See *Authorized Representative*, page 69.

Requests must be filed in writing at the following address, no later than 60 days following our decision:

Iowa Division of Insurance
330 Maple Street
Des Moines, IA 50319-0065

13. General Provisions

Contract

The conditions of your coverage are defined in your contract. Your contract includes:

- Any application you submitted to us or to your employer or group sponsor.
- Any agreement or group policy we have with your employer or group sponsor.
- Any application completed by your employer or group sponsor.
- This benefit booklet and any riders or amendments.

All of the statements made by you or your employer or group sponsor in any of these materials will be treated by us as representations, not warranties.

Interpreting this Benefit Booklet

We will interpret the provisions of this benefit booklet and determine the answer to all questions that arise under it. We have the administrative discretion to determine whether you meet our written eligibility requirements, or to interpret any other term in this benefit booklet. If any benefit described in this benefit booklet is subject to a determination of medical necessity, unless otherwise required by law, we will make that factual determination. Our interpretations and determinations are final and conclusive.

There are certain rules you must follow in order for us to properly administer your benefits. Different rules appear in different sections of your benefit booklet. You should become familiar with the entire document.

Authority to Terminate, Amend, or Modify

Your employer or group sponsor has the authority to terminate, amend, or modify the coverage described in this benefit booklet at any time. Any amendment or modification will be in writing and will be as binding as this benefit booklet. If your contract is terminated, you may not receive benefits.

Authorized Group Health Plan Changes

No agent, employee, or representative of ours is authorized to vary, add to, change, modify, waive, or alter any of the provisions described in this benefit booklet. This benefit booklet cannot be changed except by one of the following:

- Written amendment signed by an authorized officer and accepted by you or your employer or group sponsor as shown by payment of the premium.
- Our receipt of proper notification that an event has changed your spouse or dependent's eligibility for coverage. See *Coverage Changes and Termination*, page 55.

Authorized Representative

You may authorize another person to represent you and with whom you want us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in our Authorized Representative Form. This form is available at www.wellmark.com or by calling the Customer Service number on your ID card.

In a medically urgent situation your treating health care practitioner may act as your authorized representative without completion of the Authorized Representative Form.

An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your provider an authorized representative. You may authorize only one person as your representative at a time. You may revoke the authorized representative at any time.

Release of Information

You have agreed in your application (or in documents kept by us or your employer or group sponsor) to release any necessary information requested about you so we can process claims for benefits.

You must allow any provider, facility, or their employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information in your application, your benefits may be denied. If you fraudulently use your coverage or misrepresent or conceal material facts in your application, then we may terminate your coverage under this group health plan.

Privacy of Information

We are committed to protecting the privacy of your health information. We will request, use, or disclose your health information only as permitted or required by law. Wellmark has issued a *Privacy Practices Notice*. This notice is available upon request or at www.wellmark.com.

We will use or disclose your health information for treatment, payment, and health care operations according to the standards and specifications of the federal privacy regulations.

Treatment

We may disclose your health information to a physician or other health care provider in order for such health care provider to provide treatment to you.

Payment

We may use and disclose your health information to pay for covered services from physicians, hospitals, and other providers, to determine your eligibility for benefits, to coordinate benefits, to determine medical necessity, to obtain premiums, to issue explanations of benefits to the person enrolled in the group health plan in which you participate, and the like. We may disclose your health information to a health care provider or entity subject to the federal privacy rules so they can obtain payment or engage in these payment activities.

Health Care Operations

We may use and disclose your health information in connection with health care operations. Health care operations include, but are not limited to, rating our risk and determining premiums for your group health plan; quality assessment and improvement activities; reviewing the competence or qualifications of health care practitioners, evaluating provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities; medical review, legal services, and auditing, including fraud and abuse detection and compliance; business planning and development; and business management and general administrative activities.

Other Disclosures

We will obtain your explicit authorization for any use or disclosure of your health information that is not permitted or required by law. For example, at your request we may release claim payment information to a friend or family member to act on your behalf during a hospitalization by submitting an authorization to release information to that person.

Nonassignment

Benefits for covered services under this group health plan are for your personal benefit and cannot be transferred or assigned to anyone else without our consent. You are prohibited from assigning any claim or cause of action arising out of or relating to this group health plan. Any attempt to assign this group health plan or rights to payment will be void.

Governing Law

To the extent not superseded by the laws of the United States, the group health plan will be construed in accordance with and governed by the laws of the state of Iowa. Any action brought because of a claim under this plan will be litigated in the state or

federal courts located in the state of Iowa and in no other.

Legal Action

You shall not start any legal action against us unless you have exhausted the applicable appeal process and the external review process described in the *Appeals* section.

You shall not bring any legal or equitable action against us because of a claim under this group health plan, or because of the alleged breach of this plan, more than two years after the end of the calendar year in which the services or supplies were provided.

Medicaid Enrollment

Assignment of Rights

This group health plan will provide payment of benefits for covered services to you, your beneficiary, or any other person who has been legally assigned the right to receive such benefits under requirements established pursuant to Title XIX of the Social Security Act (Medicaid).

Enrollment Without Regard to Medicaid

Your receipt or eligibility for medical assistance under Title XIX of the Social Security Act (Medicaid) will not affect your enrollment as a participant or beneficiary of this group health plan, nor will it affect our determination of any benefits paid to you.

Acquisition by States of Rights of Third Parties

If payment has been made by Medicaid and Wellmark has a legal obligation to provide benefits for those services, Wellmark will make payment of those benefits in accordance with any state law under which a state acquires the right to such payments.

Subrogation

Right of Subrogation

If you or your legal representative have a claim to recover money from a third party and this claim relates to an illness or injury for which Wellmark provides benefits, Wellmark will be subrogated to you and your legal representative's rights to recover from the third party as a condition to your receipt of benefits.

Right of Reimbursement

If you are injured as a result of the act of a third party and you or your legal representative files a claim under this group health plan, as a condition of receipt of benefits, you or your legal representative must reimburse Wellmark for all benefits paid for the injury from money received from the third party or its insurer, to the extent of the amount paid by Wellmark on the claim.

Once you receive benefits under this group health plan arising from an illness or injury, Wellmark will assume any legal rights you have to collect compensation, damages, or any other payment related to the illness or injury from any of the following:

- The responsible person or that person's insurer.
- Uninsured motorist coverage.
- Underinsured motorist coverage.
- Other insurance coverage, including but not limited to homeowner's, motor vehicle, or medical payments insurance.

You agree to recognize Wellmark's rights to subrogation and reimbursement. These rights provide Wellmark with a priority over any money paid by a third party to you relative to the amount paid by Wellmark, including priority over any claim for non-medical charges, or other costs and expenses. Wellmark will assume all rights of recovery, to the extent of payment, regardless of whether payment is made before or after settlement of a third party claim, and regardless of whether you have received full or complete compensation for an illness or injury.

Procedures for Subrogation and Reimbursement

You or your legal representative must do whatever Wellmark requests with respect to

the exercise of Wellmark's subrogation and reimbursement rights, and you agree to do nothing to prejudice those rights. In addition, at the time of making a claim for benefits, you or your legal representative must inform Wellmark in writing if you were injured by a third party. You or your legal representative must provide the following information, by registered mail, within seven (7) days of such injury to Wellmark as a condition to receipt of benefits:

- The name, address, and telephone number of the third party that in any way caused the injury, and of the attorney representing the third party;
- The name, address and telephone number of the third party's insurer and any insurer of you;
- The name, address and telephone number of your attorney with respect to the third party's act;
- Prior to the meeting, the date, time and location of any meeting between the third party or his attorney and you, or your attorney;
- All terms of any settlement offer made by the third party or his insurer or your insurer;
- All information discovered by you or your attorney concerning the insurance coverage of the third party;
- The amount and location of any money that is recovered by you from the third party or his insurer or your insurer, and the date that the money was received;
- Prior to settlement, all information related to any oral or written settlement agreement between you and the third party or his insurer or your insurer;
- All information regarding any legal action that has been brought on your behalf against the third party or his insurer; and
- All other information requested by Wellmark.

Send this information to:

Wellmark Blue Cross and Blue Shield of Iowa
636 Grand Avenue, Station 151
Des Moines, IA 50309-2565

You also agree to all of the following:

- You will immediately let us know about any potential claims or rights of recovery related to the illness or injury.
- You will furnish any information and assistance that we determine we will need to enforce our rights under this group health plan.
- You will do nothing to prejudice our rights and interests including, but not limited to, signing any release or waiver (or otherwise releasing) our rights, without obtaining our written permission.
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without obtaining our written permission.
- If payment is received from the other party or parties, you must reimburse us to the extent of benefit payments made under this group health plan.
- In the event you or your attorney receive any funds in compensation for your illness or injury, you or your attorney will hold those funds (up to and including the amount of benefits paid by Wellmark in connection with the illness or injury) in trust for the benefit of Wellmark as trustee(s) for Wellmark until the extent of our right to reimbursement or subrogation has been resolved.

In the event Wellmark deems it necessary to institute legal action against you if you fail to repay Wellmark as required in this group health plan, you shall be liable for the amount of such payments made by Wellmark as well as all of Wellmark's costs of collection, including reasonable attorney fees and costs.

You and your covered family member(s) must notify us if you have the potential right to receive payment from someone else. You must cooperate with us to ensure that our rights to subrogation are protected.

Wellmark's right of subrogation and reimbursement under this group health plan applies to all rights of recovery, and not only to your right to compensation for medical expenses. A settlement or judgment structured in any manner not to include medical expenses, or an action brought by you or on your behalf which fails to state a claim for recovery of medical expenses, shall not defeat our rights of subrogation and reimbursement if there is any recovery on your claim.

We reserve the right to offset any amounts owed to us against any future claim settlement amounts.

Workers' Compensation

If you have received benefits under this benefits plan for an injury or condition that is the subject or basis of a workers' compensation claim (whether litigated or not), we are entitled to reimbursement to the extent of benefits paid under this plan from your employer, your employer's workers' compensation carrier, or you in the event that your claim is accepted or adjudged to be covered under workers' compensation.

Furthermore, we are entitled to reimbursement from you to the full extent of benefits paid out of any proceeds you receive from any workers' compensation claim, regardless of whether you have been made whole or fully compensated for your losses, regardless of whether the proceeds represent a compromise or disputed settlement, and regardless of any characterization of the settlement proceeds by the parties to the settlement. We will not be liable for any attorney's fees or other expenses incurred in obtaining any proceeds for any workers' compensation claim.

We utilize industry standard methods to identify claims that may be work-related. This may result in initial payment of some claims that are work-related. We reserve the right to seek reimbursement of any such claim or to waive reimbursement of any claim, at our discretion.

Payment in Error

If for any reason we make payment in error, we may recover the amount we paid.

Notice

If a specific address has not been provided elsewhere in this benefit booklet, you may send any notice to Wellmark's home office:

Wellmark Blue Cross and Blue Shield of Iowa
636 Grand Avenue
Des Moines, IA 50309-2565

Any notice from Wellmark to you is acceptable when sent to your address as it appears on Wellmark's records or the address of the group through which you are enrolled.

Glossary

The definitions in this section are terms that are used in various sections of this benefit booklet. A term that appears in only one section is defined in that section.

Accidental Injury. An injury, independent of disease or bodily infirmity or any other cause, that happens by chance and requires immediate medical attention.

Admission. Formal acceptance as a patient to a hospital or other covered health care facility for a health condition.

Benefit Year. A calendar year, starting over each January 1. A benefit year continues even if you change coverage under group health plans sponsored by your employer or group sponsor and administered by Wellmark.

Benefits. Medically necessary services or supplies that qualify for payment under this group health plan.

Billed Charge. The amount that a provider bills for a service or supply or the retail price that a pharmacy charges for a prescription drug.

BlueCard Program. The Blue Cross and Blue Shield Association program that permits members of any Blue Cross or Blue Shield Plan to have access to the advantages of participating Network providers throughout the United States.

Covered Charge. The billed charge for a service or supply that qualifies for benefits.

Creditable Coverage. Any of the following categories of coverage, during which there was no break in coverage of more than 63 days:

- Group health plan (including government and church plans).
- Health insurance coverage (including group, individual, and short-term limited duration coverage).
- Medicare (Part A or B of Title XVIII of the Social Security Act).
- Medicaid (Title XIX of the Social Security Act).
- Medical care for members and certain former members of the uniformed services, and for their dependents (Chapter 55 of Title 10, United States Code).
- A medical care program of the Indian Health Service or of a tribal organization.
- A state health benefits risk pool.
- Federal Employee Health Benefit Plan (a health plan offered under Chapter 89 of Title 5, United States Code).
- A State Children's Health Insurance Program (S-CHIP).
- A public health plan as defined in federal regulations (including health coverage provided under a plan established or maintained by a foreign country or political subdivision).
- A health benefits plan under Section 5(e) of the Peace Corps Act.
- An organized delivery system licensed by the director of public health.

Global Pricing Arrangement. An all-inclusive payment arrangement between a transplant center and us or the national Blue Cross and Blue Shield Association. It bundles all transplant costs for hospitalization, physician fees, and organ procurements into one charge.

Group. Those plan members who share a common relationship, such as employment or membership.

Group Sponsor. The entity that sponsors this group health plan.

Illness or Injury. Any bodily disorder, bodily injury, disease, or mental health condition, including pregnancy and complications of pregnancy.

Inpatient. Services received, or a person receiving services, while admitted to a health care facility for at least an overnight stay.

Maintenance. An industry-wide classification for prescription drug treatments to control specific, ongoing health conditions.

Medical Appliance. A device or mechanism designed to support or restrain part of the body (such as a splint, bandage or brace); to measure functioning or physical condition of the body (such as glucometers or devices to measure blood pressure); or to administer drugs (such as syringes).

Medically Urgent Situation. A situation where a longer, non-urgent response time to a pre-service notification could seriously jeopardize the life or health of the benefits plan member seeking services or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be managed without the services in question.

Medicare. The federal government health insurance program established under Title XVIII of the Social Security Act for people age 65 and older and for individuals of any age entitled to monthly disability benefits under Social Security or the Railroad Retirement Program. It is also for those with chronic renal disease who require hemodialysis or kidney transplant.

Member. A person covered under this group health plan.

Nonparticipating Pharmacy. A pharmacy that does not participate with the network used by this prescription drug benefits plan.

Nonparticipating Provider. A facility or practitioner that does not participate with a Blue Cross or Blue Shield Plan.

Outpatient. Services received, or a person receiving services, in a practitioner's office, the home, the outpatient department of a hospital, or an ambulatory surgery center.

Participating Pharmacy. A pharmacy that participates with the network used by this prescription drug benefits plan.

Participating Provider. A facility or practitioner that participates with a Blue Cross or Blue Shield Plan.

Plan Member. The person who signed for this group health plan.

Residential Treatment. Treatment of mental health conditions or chemical dependency that meets the following criteria:

- Treatment is provided in a 24-hour residential setting;
- Treatment is for severe, persistent, or chronic mental health conditions or chemical dependency;
- Treatment involves therapeutic intervention and specialized programming with a high degree of structure and supervision;
- Treatment includes training in basic skills such as social skills and activities of daily living; and
- Treatment does not require daily supervision of a physician.

Services or Supplies. Any services, supplies, treatments, devices, or drugs, as applicable in the context of this benefit booklet, that may be used to diagnose or treat a medical condition.

Settlement Amount. The amount that is discharged when your claim is processed.

Spouse. A husband or wife as the result of a marriage that is legally recognized in Iowa, including common law.

We, Our, Us. Wellmark Blue Cross and Blue Shield of Iowa.

X-ray and Lab Services. Tests, screenings, imagings, and evaluation procedures identified in the American Medical Association's Current Procedural Terminology (CPT) manual, Standard

Edition, under *Radiology Guidelines* and *Pathology and Laboratory Guidelines*.

You, Your. The plan member and family members eligible for coverage under this group health plan.

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